IDAHO BOARD OF HEALTH AND WELFARE
MINUTES
August 17, 2017

The Board of Health and Welfare convened at:
Pete T. Cenarrusa Building
450 W. State Street
Boise, Idaho 83720

BOARD MEMBERS PRESENT

Darrell Kerby, Chairman
Tom Stroschein, Vice-Chair
Russ Barron, Secretary
Dr. Richard Roberge
James Giuffré
Stephen Weeg
Janet Penfold
Tammy Perkins

STAFF PRESENT

Lisa Hettinger, Deputy Director, Behavioral Health, Medicaid, Public Health, and the OHPI
David N. Taylor, Deputy Director, Support Services
Lori Wolff, Deputy Director, FACS and Welfare Services
Kathie Brack, Special Assistant to the Director
Elke Shaw-Tulloch, Division Administrator, Public Health
Tamara Prisock, Division Administrator, Licensing and Certification
Chris Smith, Public Information
Lynn Overman, Liaison to the Board

OTHERS PRESENT

Nicole McKay, Office of the Attorney General; Chief, Health and Human Services
Jared Tatro, Legislative Services Office, Principal Budget and Policy Analyst
Bill Benkula, Idaho Association of Community Providers (IACP)
Shelly Brubaker, IACP
Teronda Robinson, IACP
Nicole Sherwood, IACP
Kathy Gneiting, Idaho Federation of Families for Children's Mental Health
Norma Jaeger, Recovery Idaho, Inc.

CALL TO ORDER

Following proper notice in accordance with Idaho Code, Section 67-2343, and pursuant to call by the Chairman, the meeting of the Idaho Board of Health and Welfare was called to order by

Darrell Kerby, Chairman of the Board, at 8:05a.m. Thursday, August 17, 2017, at the Pete T. Cenarrusa Bldg., 450 W. State Street, Boise, Idaho.

ROLL CALL

Russ Barron, Secretary, called the roll. Roll call showed eight **(8)** members present. With **six (6)** voting members present, Chairman Kerby declared a quorum. Absent and excused was Wendy Jaquet.

PUBLIC COMMENT PERIOD

Chairman Kerby opened the floor for public comment. There being none, the Board advanced to the next order of business.

ADOPTION OF MINUTES FROM BOARD MEETING ON MAY 18, 2017

Motion: Stephen Weeg moved that the minutes of the May 18, 2017 Board meeting be adopted as prepared.

Second: Jim Giuffré

Roll Call Vote:

Ayes: Giuffré, Kerby, Stroschein, Weeg, Penfold, Roberge
Nays: None
Absent: Wendy Jaquet

Motion Carried

MEDICAID – RESIDENTIAL REHABILITATION UPDATE

Matt Wimmer, Division Administrator of Medicaid, gave a PowerPoint presentation on Medicaid Residential Habilitation Reimbursement. (See Attachment 1)
There was some discussion on direct care worker wages, as well as participant/staff ratio. Medicaid will continue to evaluate wages based on feedback from providers. Current rules are followed regarding ratios, based on individual client needs. This reimbursement rate relates to individuals in private residences, rather than facilities.

IACP – PRESENTATION

Bill Benkula from the Idaho Association of Community Providers gave a PowerPoint presentation entitled, "Partnership for Building Quality and Sustainable Supports for Idahoans with Disabilities." He also provided supplemental documents (See Attachments 2, 3 and 4)
The Department has been helpful in resolving many impasses and cooperation has been appreciated.
Legally, decisions regarding wage increases are outside of the Board's jurisdiction, per Nicole McKay, Lead Deputy Attorney General. Chairman Kerby thanked Mr. Benkula and the IACP for their presentation.

COMMENTS FROM BOARD MEMBERS

Looking forward to 2018 healthcare, there is speculation that there will be no subsidies from the federal government, as no concrete budget has been received. We must move forward with tax credit eligibility based on the information we currently have. Should subsidies be received after rates are set and plans chosen, the tax credit eligibility would need to be recalculated – potentially every month.

OPIOID ADDICTION PRESENTATION

Tom Stroschein provided an editorial handout on the opioid addiction epidemic. (Attachment 5) He also introduced his guest, Norma Jaeger, Director of Recovery Idaho, Inc. Ms. Jaeger has taken a leadership role in creating a recovery-oriented system for treatment of opioid addiction. Start-up costs were funded through the Millennial Fund, but new funding sources for staffing are crucial. Proper training for, and endorsement of coaches is needed, as well as medication assisted treatment. The success of these systems is directly related to the involvement of the community. Focus will be needed to create awareness about help available to those in need.

Tom also introduced his second guest, Kathy Gneiting. Kathy presented a video on opioid abuse, as experienced by her daughter, who eventually died from overdose. Kathy's work has since focused on creating a 'voice' advocacy group to hold community conversations about the growing epidemic of opioid abuse. Awareness is crucial. Education is needed, for example, to know that pain is a normal part of surgery recovery, and removal of **all** pain by opioid prescription is not desirable at the risk of addiction. Also, any opioid prescription should be viewed as a potential addiction from the start. Recovery needs to be understood as a lifelong process, and the need for community recovery centers is high.
Norma Jaeger stated that Idaho currently has 8 recovery centers. With no funds available, many of these centers will close within the next 2 years. Staff is presently 100% volunteer. As communities become aware that the effects of addiction are broad reaching schools, hospitals, police forces, etc., they see the need to support recovery centers. Advocacy groups have been active in reaching as many community members as possible, including county commissioners and state legislators.

BOARD CONCURRENCE OF APPOINTMENTS

Director Barron introduced Catherine Libby, Julie Hammon and Jim Price and briefly reviewed their new positions within the Department. (See Attachments 6, 7, 8 for Curriculum Vitae)

- Catherine Libby – Division Administrator of Operational Services. Cathy's recent background has been as the Deputy Administrator of Operations in Medicaid, with many roles in the Department prior to that, primarily in social work. Her goals in her new position are to make the physical facilities safe and comfortable for employees, standardize processes for growth and development, and to assist management for increased and improved performance.

MOTION: Jim Giuffré moved that the Board concur with the appointment of Catherine Libby, Division Administrator of Operational Services, by the Department of Health and Welfare, Director Russell S. Barron.

SECOND: Stephen Weeg

Roll Call Vote:

Ayes: Giuffré, Kerby, Stroschein, Weeg, Penfold, Roberge
Nays: None
Absent: Wendy Jaquet

Motion Carried

- Julie Hammon – Division Administrator of Welfare. Julie has worked for the Department for 26 years. Her most recent position as Deputy Administrator, Division of Welfare, has allowed her to build relations with federal agencies and develop relations with Your Health Idaho staff. Her goals are to improve and expand our programs. With strong foundations in place, we have the ability to do so quickly and efficiently.

MOTION: Stephen Weeg moved that the Board concur with the appointment of Julie Hammon, Division Administrator of Welfare, by the Department of Health and Welfare, Director Russell S. Barron.

SECOND: Tom Stroschein

Roll Call Vote:

Ayes: Giuffré, Kerby, Stroschein, Weeg, Penfold, Roberge
Nays: None
Absent: Wendy Jaquet

Motion Carried

- James Price – Administrator of State Hospital South. Jim's prior experience has been as attorney for SHS, in which he developed strong relationships with the staff. Most recently, he worked as the Assistant Administrator, focusing on patient and HR issues, budget, facilities and maintenance. His goals are to improve the quality of patient care and improve safety for patients and staff. Recent improvements have included: Staff badges with electronic capability to record emergencies and the areas they occur, better lighting and security cameras, advanced skills training for dealing with client violence, heightened security fences to eliminate escapes and the recent 130th year celebration to reduce the stigma of the center in the community.

MOTION: Stephen Weeg moved that the Board concur with the appointment of James Price, Administrator of State Hospital South, by the Department of Health and Welfare, Director Russell S. Barron.

SECOND: Jim Giuffré

Roll Call Vote:

Ayes: Giuffré, Kerby, Stroschein, Weeg, Penfold, Roberge
Nays: None
Absent: Wendy Jaquet

Motion Carried

DIVISION OF SUPPORT SERVICES UPDATE

Dave Taylor, Deputy Director of Support Services, presented and reviewed 2 documents:

1. SFY 2017 Actuals
2. SFY 2018 and SFY 2019 Budget Request

(See Attachments 9 & 10)

- SFY 2017 Actuals:
  - Summary of fiscal year 2017 actual expenditures of the Department of Health and Welfare was discussed.
- SFY 2018 and SFY2019 Budget Request:
  - Supplemental request: Describe changes to the appropriation that adds to or adjusts spending authority in the current fiscal year (SFY 2018).
  - Maintenance Items: Request for resources needed to continue current levels of service (SFY 2019).
  - Line items: Additional decision units requesting funding for new or expanded activities after maintenance of current operations (SFY 2019).
- Update regarding the uncertainty surrounding the federal budget.

STRATEGIC PLAN UPDATE

Tamara Prisock, Division Administrator for Licensing and Certification, provided printouts of an Overview of the Plan, a breakout of the Strategic Initiatives, and the Strategic Plan (See Attachments 11, 12, 13)

This year, we have refined 3 of the initiatives and added performance measures:

1. Showing how we are moving from a volume based healthcare plan to a value based plan.
2. Added the new strategic plan requirement to report progress on implementing Idaho's state government Cyber Security Plan.

Some performance measures are still in the implementation stage, so they will have targets for tasks to monitor progress.

WELFARE/ FAMILY AND COMMUNITY SERVICES UPDATE

Welfare: Lori Wolff, Deputy Director, reported that the Open Enrollment period has been shortened by one month. Work is being done with Your Health Idaho and the Idaho Exchange to simplify and build web tools.

The Department contracted with Maximus in September of 2016 to enhance training and placement for those who must fulfill the work requirement for benefits eligibility. The Department also acts as a pass-through for federal funds to support community service providers that assist with work training and placement. Long-term placement continues to be a struggle. We are developing ideas to help individuals attend Community College and obtain degrees.

FACS: Three of the four patients from the now closed Kyler House have been successfully placed. We are working to place the fourth patient in an appropriate setting. The physicians from Kyler House have been reassigned to other clinics, and the funds have been reinvested in SWITC, Clinical Care Supervisors, and the Infant Toddler Program.
The Child Welfare program continues to be improved as we evaluate feedback from the Interim Committee and the OPE Report. Understaffing of social workers is a key issue. Focus on policy, rules and budgeting have taken precedence over staff support. Regions 3 and 4 are particularly in need of more staff.
As the new Eastern Hub Regional Director, Chris Freeburne has been very involved in the community, creating needed communication for training and process improvement. The Legislative Interim Committee met in July and is looking for a long-term plan.

BEHAVIORAL HEALTH, PUBLIC HEALTH, AND SHIP UPDATE

Behavioral Health: Lisa Hettinger, Deputy Director, reported that the first crisis center to receive start-up funding was approaching the second phase of state participation in their operating costs. The original legislation for these centers envisioned that during this phase, the community would need a sustainability plan that included funding for 50% of their operating costs. Many legislative requests to continue funding and even consider not requiring the 50% community match have been made. To spite long-term funding challenges for these centers, we must come up with a plan that recognizes how key community involvement is to the long-term success of these services. When a community remains actively engaged they are more likely to adopt an entire system of care that fits their community's unique needs. For example, region 2 developed a unique model for crisis care that does not mirror the two operational crisis centers in the state. Region 2 will be establishing 1 or 2 rooms in 5 hospitals and using a roving psychiatrist. Five county commissions were involved in developing this promising model of care.
An independent assessment contractor for the Youth Empowerment Services (YES) project will be in place January 1, 2018 allowing us to take the first steps towards the new service model for the members of the class.
A model has been developed for Homes for Adult Residential Treatment (HART), and it is ready for contracts with facilities who have transitioned to the model of care.

Public Health: We will need to bring a budget request again this year to continue access to a seizure medication (Epidiolex) that is showing marked improvements for the 36 children in a pilot program. This funding is necessary as there has been an unanticipated delay in approval of the drug by the federal government.
Eight states, including Idaho, will take part in a Federal Emergency Response Exercise, September 11-13. The exercise will include landing a 747 at the Boise Airport to facilitate transporting simulated Ebola patients from St. Luke's Hospital to Spokane.

Over twenty health systems will partner with the Department to provide training, response and data collecting to improve the outcomes for those at risk for suicide.
Since 2001, there has been a steady increase in opioid overdose deaths. Actual numbers are difficult to quantify because of the stigmas around addiction and suicide, which effects accurate reporting. Recently, the Department was awarded two grants to implement our plan for addressing Opioid addiction in Idaho. There are many strategies we will implement that are detailed in your meeting information (see attachment 14). One example is implementing Prescription Drug Monitoring Programs (PDMP) in conjunction with the Board of Pharmacy and providers.
An electronic copy of the publication "Get Healthy Idaho: Measuring and Improving Population Health" can be found online at http://gethealthy.dhw.idaho.gov.

State Healthcare Innovation Plan (SHIP): There are 2 years left in Idaho's SIM grant period. Idaho is one of the few states to monitor clinical measures, and we envision providing the tools that will allow payers and providers to focus on clinical data for improved quality outcomes. For those reasons, should portions of CMMI funding be threatened by the federal government changing their budget, we feel well positioned to continue receiving the necessary funds to continue this delivery system transformation work. In addition to the SIM funds, the federal government is willing to sponsor 90% of the cost of connecting clinics to the Idaho Health Data Exchange (IHDE) through the Medicaid program. These connections provide information that is critical to the Medicaid payment reform, and they will make critical pieces of clinical data available to all providers in the state who are connected to the IHDE.
A SHIP blog was launched 7/27/17 and providers have responded positively about the real-time information available. Four Public Health Districts have been awarded Grants to better connect their medical neighborhoods.

Medicaid: VEYO has a corrective action plan in place to deal with continued scheduling problems.

DIRECTOR'S UPDATE

Russ Barron, Director, reported that despite ambiguity at the federal level, the Department's divisions are moving forward, and he is pleased with the leadership and hard work at all levels.

Many divisions have been working with other state agencies to prepare for the Solar Eclipse and expected influx to the State that will occur Monday, 8/21/17. State offices will remain open for services.

Former Director Dick Armstrong is still very involved with and dedicated to solutions for handling the GAP population in Idaho – those who earn too much to qualify for Medicaid, yet too little to qualify for subsidies. He has been appointed by Governor Otter to chair the Health Care Advisory Panel (HCAP). Dual waivers will be submitted to the U.S. Department of Health and Human Services (HHS):

1.) The Department of Health and Welfare (DHW) to the Centers for Medicare and Medicaid Services (CMS).

2.) Department of Insurance (DOI)/Your Health Idaho (YHI) to the Center for Consumer Information and Insurance Oversight (CCIIO).

The dual waivers must prove cost neutrality, and participants must have earned income.

Board members were invited to attend Employee Appreciation events in their respective areas, to become familiar with Department employees and the programs they provide.

EXECUTIVE SESSION

MOTION: Stephen Weeg moved that the Board, Pursuant to Idaho Code §74-206, convene in Executive Session to communicate with legal counsel regarding pending/imminently-likely litigation [Idaho Code §74-206(1)(f)] regarding the SWITC Investigation.

SECOND: Jim Giuffré

Roll Call Vote:

Ayes: Giuffré, Kerby, Stroschein, Weeg, Penfold, Roberge
Nays: None
Absent: Wendy Jaquet

Motion Carried

Monica Young, Manager of Human Resources, reported to the Board on the Investigation.

No final action was taken and no final decision was made by the Board.

MOTION: Jim Giuffré moved that the Board end the Executive Session.

SECOND: Tom Stroschein

Roll Call Vote:

Ayes: Giuffré, Kerby, Stroschein, Weeg, Penfold, Roberge
Nays: None
Absent: Wendy Jaquet

Motion Carried

ADJOURNMENT

The next meeting of the Idaho Board of Health and Welfare is scheduled to be held November 16, 2017. There being no further business to come before the Board, Chairman Kerby adjourned the meeting at 3:20p.m.

Respectfully signed and submitted by:

Darrell Kerby, Chairman

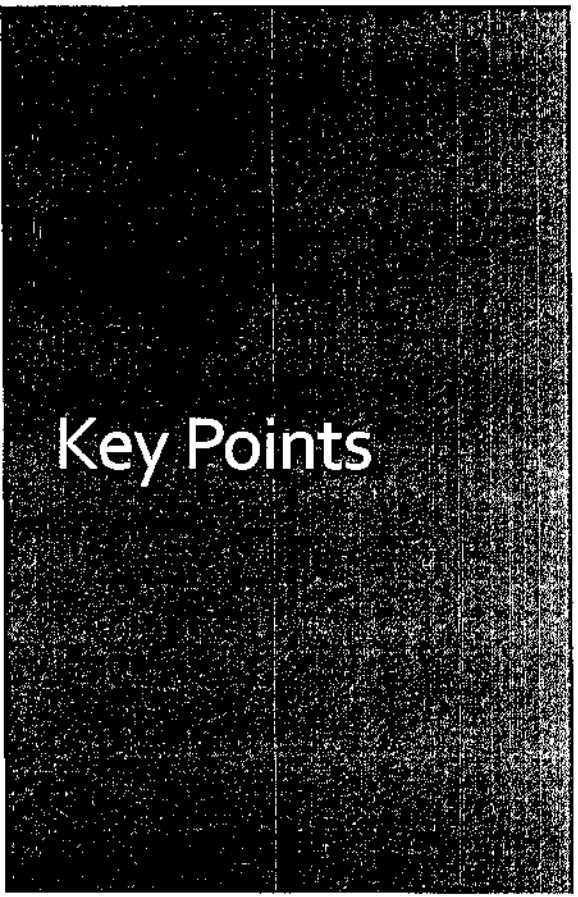
Russell S. Barron, Secretary

Lynn Overman, Liaison to the Board

ATTACHMENT 1

Medicaid Residential Habilitation Reimbursement

Idaho Board of Health and Welfare



- Idaho's approach to rate setting is consistent with the "Arizona Model" approach.
- Medicaid cost surveys and rate setting are prescribed in Idaho code and IDAPA rule.
- Medicaid has worked with the IACP and other residential habilitation providers to ensure that our cost survey is accurate and professional.

Arizona Model

- Idaho uses the same "bricks" as the Arizona Model or Brick Method
  - Direct care wages
  - Employee related expenses
  - Program related expenses, and
  - General and administrative expenses
- Idaho has and continues to support the fundamentals of this approach.
- Like many other states, Idaho's approach to reimbursement is customized based on state needs.

Arizona Model

- Many states assume program related and administrative expenses are a percentage of direct care wages
- Once that percentage is established, they can adjust rates without completing a cost survey based on changes in direct care wages alone
- Idaho rules and statute do not allow for changing rates without a cost survey or legislative approval, so we do not have a need for this method, nor is it supported in law

Idaho Law – Provider Reimbursement

- Idaho Code (56-265, 56-118) and rules (IDAPA 16.03.10.037) are Medicaid's legislative direction and legal requirements for setting these rates
- 56-118 requires a methodology linked to actual cost
- Current Idaho rule was reviewed by the legislature in 2013
- "Cost surveys to collect indirect general, administrative, and program related costs will be used when these expenditures are incurred by the provider type executing the program."
- "*The costs will be ranked by costs per provider*, and the Medicaid cost used in the reimbursement rate methodology will be established at the seventy-fifth percentile in order to efficiently set a rate"

Idaho Law – Provider Reimbursement

- In keeping with rule, Medicaid staff and our contractor Myers and Stauffer have worked with providers to collect information on their costs and wages.
- Rules do not currently support using a blended approach – there are only two options for direct care staff wages:
  - A single occupational category from federal Bureau of Labor Statistics data or
  - The average wage from the cost survey if no occupational category is a good fit.
- We chose the most comparable BLS category we could find to avoid using the lower average amount ($10.47 vs. $9.60)
- We must ask the legislature for funding approval for rate changes.

Collaborative Approach

Medicaid has worked extensively with providers to address their concerns

- Numerous meetings
- Contracted with Navigant to review our approach and provide feedback
- Initiated additional survey work around ratio of provider staff to participants to ensure a full picture of costs for rate-setting
- Initiated negotiated rulemaking to address provider concerns and Department needs
- While we must use our current rules, we are open to improving our approach in collaboration with the provider and participant community

ATTACHMENT 2

Partnership for Building Quality and Sustainable Supports for Idahoans with Disabilities

Presented by the Idaho Association of Community Providers

August 17, 2017

Why We Are Here

- To provide an update on where we are at in partnering with the Department of Health and Welfare to ensure quality, accessible, and sustainable services
- To answer questions you had from our last presentation on May 18
  - Background on the Arizona model (rate methodology)
  - Duties of Direct Support Professionals
  - Fiscal Impact

Recap of Who We Are

- The Idaho Association of Community Providers (IACP) is made up of the following community-based services providers all across the State of Idaho:
  - Supported living (Residential Habilitation)
  - Developmental Disabilities Agencies (day habilitation and behavioral intervention services for children and adults)
  - Vocational Service Providers
  - Targeted Service Coordinators
- Services are specialized for people with intellectual/developmental disabilities allowing them to live in and participate in their local communities.
- Sole funding source is Medicaid (combination of 71% federal and 29% state dollars).

Background on the Arizona Model (Today known as the "Brick Method")

- Cost Components of Service Provision are Captured in Four Categories
  - Direct Service Staff Wage (DCW) - The staff who are performing the tasks in the furtherance of the objectives of the service. The person who is receiving the service is present most of the time.
  - Employee Related Expenses (ERE) - Discretionary and non-discretionary employee benefits such as medical benefits, paid time off, sick leave, 401(k), payroll taxes, social security, Medicare, etc.
  - Program Related Expenses (PRE) - Expenditures that support the objectives and the provision of the service, but cannot be tied to any particular person receiving the service. Examples include supervision of Direct Service Staff, supplies related to the service, consultative services to general staff, staff training, transportation, and facility costs to name a few. These costs are typically driven by service descriptions and the funding source regulations.
  - General and Administrative (G&A) - Cost of being in business. Common across any business.

Background on the Arizona Model (Today known as the "Brick Method")

BASIC FORMULA CONTRUCTION

From General Ledgers:	Total Direct Care Wages	$1,000	% of DCW
	Total ERE	$ 300	30%
	Total PRE	$ 250	25%
	Subtotal	$1,550	

Convert to an Hour (the "Brick)

Wage =	$10.00
ERE =	$ 3.00
PRE =	$ 2.50
Subtotal	$15.50
Add G&A 10%	$ 1.72
Fully loaded Hour "Brick"	$17.22

CONVERT FROM THE BRICK TO THE RATE

Example Residential Habilitation: 1:1 service 24 hours/day = 24 x $17.22 (Brick) = $413.28 daily rate

Support for the Model

- Supported by Leslie Clement, Idaho Medicaid Administrator in 2006
- Supported by Larry Tisdale, Finance Bureau Chief in 2008
- Supported by providers
- Supported by Senate and House Health & Welfare Committees in 2012
- Supported by CMS as evidenced by use in multiple states including Minnesota, North Dakota, Oregon, Arizona, New York, New Jersey, and Maryland
- Recommended by Navigant (3rd party consultant brought in to review the work of Myers & Stauffer and to make recommendations to the Department regarding rate methodology) in their July 2017 report.

Benefits of the Model

- Benefits to the Individuals Supported and Their Families
  - Responds to the individuals level of need by being variable according to direct service staff levels. Also, variable by differences in service standards.
  - Utilizing an accurate and competitive wage basis for the direct care staff can result in decreased staff turnover, higher quality and improved retention of staff, all leading to enhanced support and consistency in service delivery.
- Benefits to the Department
  - Uniformity in rates = greater predictability of costs
  - Future rate studies/updates are less burdensome
- Benefits to Providers
  - Provides a fair, equitable, and transparent system for determining rates
  - Allows for adjustment in rates when rules/standards change and to align with prevailing market wages
- Public Trust - Introduces accountability for both providers and the Department

A Day in the Life of a Direct Support Professional...

Darin

Suzanne - DSP

What are the Duties and Responsibilities of Residential Habilitation Direct Service Staff?

- Per IDAPA 16.03.10.703: Habilitation services aimed at assisting the individual to acquire, retain, or improve his ability to reside as independently as possible in the community or maintain family unity.
- Habilitation services include training in the following areas:
  - Self-direction, including the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities
  - Money management including training or assistance in handling personal finances, making purchases, and meeting personal financial obligations
  - Daily living skills including training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self-administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid, and emergency procedures
  - Socialization including training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community.

Duties and Responsibilities of Residential Habilitation Direct Service Staff (Cont.)

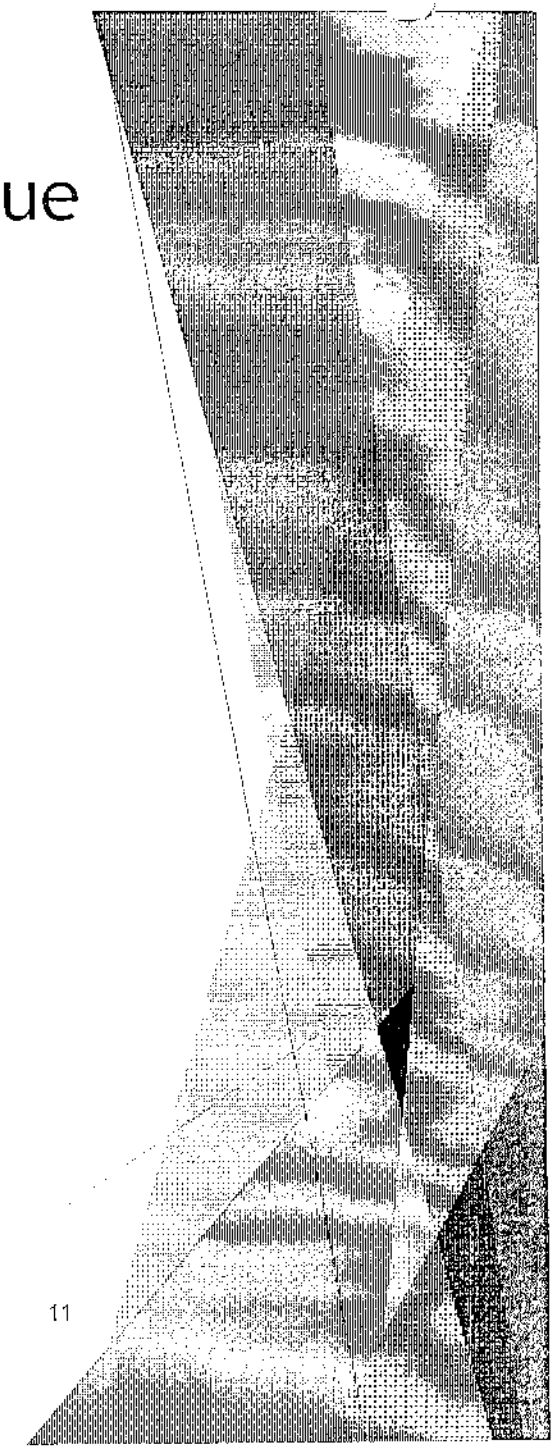
- Mobility, including training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community
- Behavior shaping and management includes training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or extension of therapeutic services, which consist of reinforcing physical, occupational, speech and other therapeutic programs

- Personal Assistance Services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the participant or the participant's primary caregiver(s) are unable to accomplish on his own behalf
- Skills training to teach waiver participants, family members, alternative family caregiver(s), or a participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training.

Direct Staff Wage Basis - A Pivotal Issue

- Provider Workforce Data (2016)
  - Direct service staff turnover in excess of 100%
  - Overtime in excess of 10-15%
  - Employee vacancy rates in excess of 20%

AGENCY	TURNOVER RATE	STAFF VACANCIES
Aspire	80%	10-20%
S.L Start	86%	10-20%
Inclusions	127%	
H.A.S	77%	21%
Ambitions	103%	25-32%
W.D.B Inc.	104%	24%
CIL	50%	
C.O.C	206%	
A&R Case mgmt	121%	13%
Independent Living Specialists	91%	

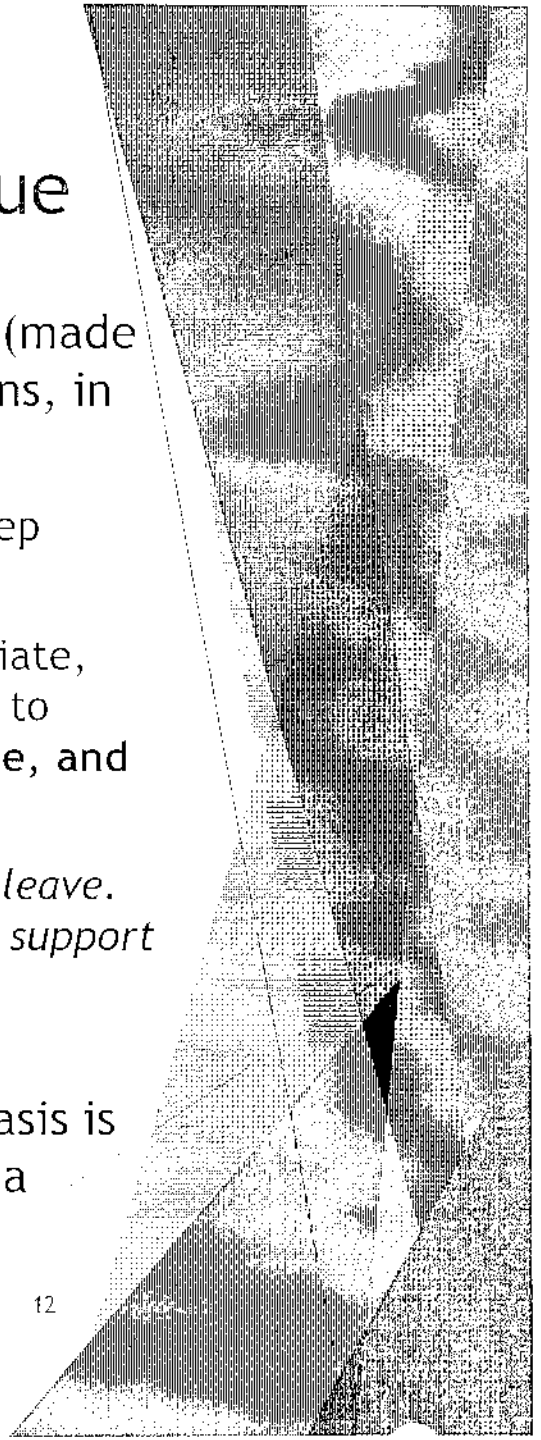


Direct Staff Wage Basis - A Pivotal Issue

- Recommendations from Community Now Work Groups (made up of supported individuals and their families/guardians, in response to KW Lawsuit)
  - Put mechanisms in place that help find, support, and keep **competent, consistent, capable, and quality staff.**
  - Implement a tiered, linguistically and culturally appropriate, training process that is standardized and person specific to ensure that all staff draw from best practice, **experience, and knowledge.**

"There is high staff turnover. Staff receive training and leave. Particularly for adults with complex medical or behavioral support needs, turnover is more than an inconvenience - it is a safety issue."

- Utilization of the correct BLS occupational category basis is **CRITICAL** for quality and sustainable services built on a stable workforce.



The "Burger King Effect"

Excerpt from page 17 of the original report from JVGA submitted to the Department in November 2006

The "Burger King Effect": This phrase has been used by JVGA staff to describe the difficulties provider agencies have in retaining appropriate staff. It may appear intuitive that unskilled labor at one business should be paid a similar wage as those others in another business. Nevertheless, this is not so in cases of private providers of services to people with developmental disabilities. While the qualifications of an individual working at a fast food restaurant may be identical to those in a community-based program for people with developmental disabilities, the conditions in which the jobs are done are very different. In other words, if the wages paid for direct staff are not reflective of the special dedication the job requires, the staff will opt for simpler jobs that pay the same. For this reason, JVGA does not use an unskilled labor category to determine wages for Direct Service Staff.

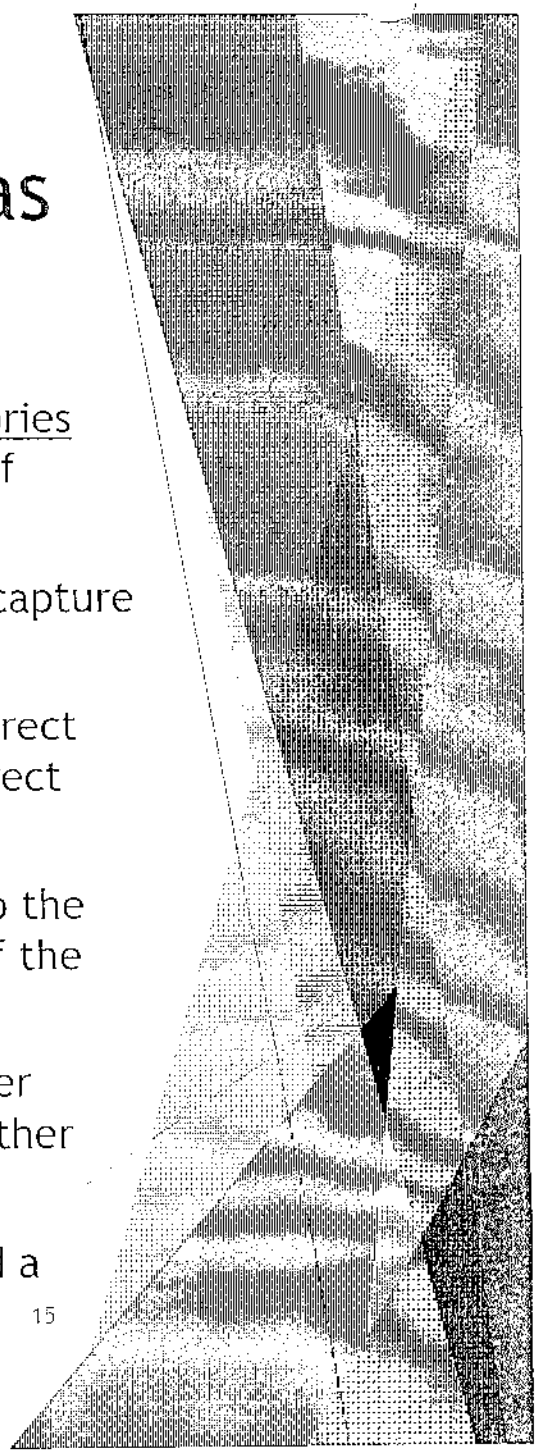
"People with developmental disabilities present very different needs than do individuals buying hamburgers. They are a wonderful but vulnerable segment of our population and it takes a special level of dedication to provide the kinds of supports they need."

Direct Staff Wage Basis - Selection of Accurate BLS Occupational Category

- The Department continues to insist on Personal Care Aide as the BLS occupational category most aligned with the direct service staff despite continued pushback from providers.
- Navigant found the following (as stated in their July 10, 2017 report):
  - Page 8: "The DHW approach does not cover the habilitation aspect of the service..."
  - Page 9: "Using a **blend of wages from BLS is a very common approach** and allows states to recognize the diversity of staff skills needed to provide services..."
  - Page 6: Possible BLS categories: Home Health Aide, Personal Care Aide, Social and Human Services Assistants, Rehabilitation Counselors.
- Navigant, the Department, and providers agree that Personal Care Aide does not capture key components of the direct staff role including skills training, medical support, and behavior management.
- The Provider Association recommended the following **blend** in a letter to the Department dated December 21, 2016: Home Health Aide (28.5%), Personal Care Aide (28.5%), Psychiatric Technician (43%).
- JVGA (rate consultant) letter to the Department dated December 23, 2016 states: "We recommend that the state consider adopting a wage based on the **average of the three potential job descriptions** cited in the BLS data and present in the IACP document BLS Occupational Category Skills and Outcomes Weighting..."

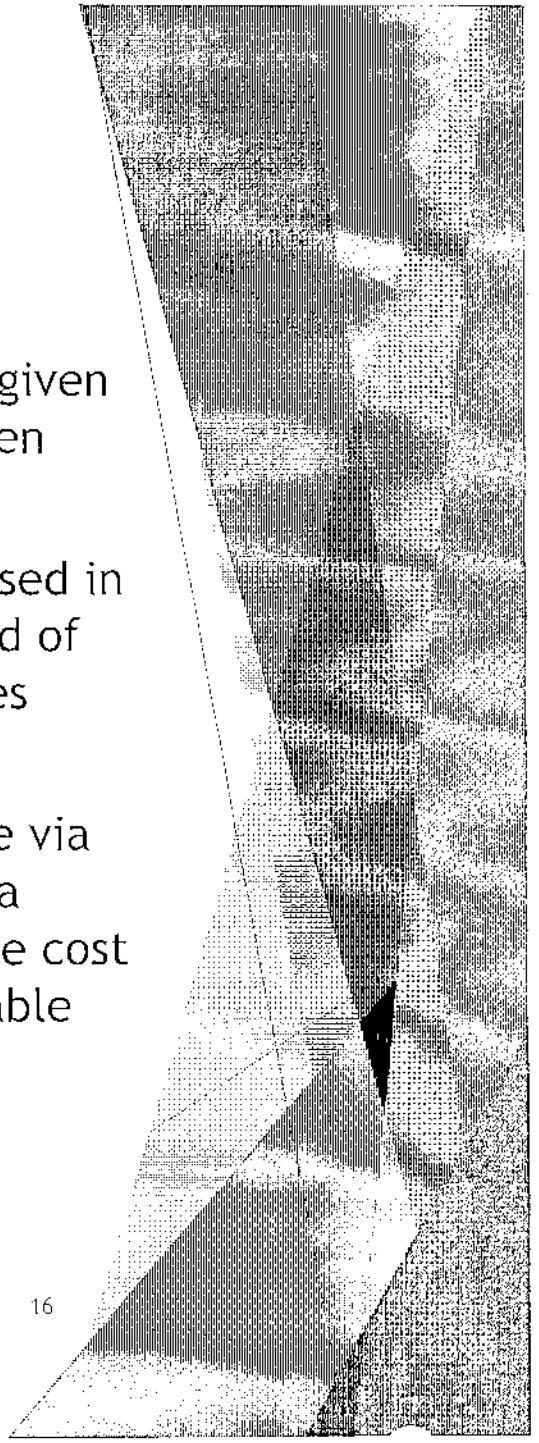
Critical Elements of the Current as Well as Future Studies

- Allow weighted average of a blend of BLS occupational categories for proposing direct staff wages and include a measure of staff retention for evaluating adequacy of the wage
- Collect and incorporate staffing ratios in order to accurately capture level of care
- Include use of a productivity factor to account for the time direct service staff spend in staff meetings, training, and other indirect time.
- Per Navigant recommendation, inflate wages/costs forward to the mid-point of the Waiver year/period to account for the age of the data collected in the study.
- Incorporate some basis for providing annual adjustments either based on Consumer Price Index, Employment Cost Index, or other mechanism to allow for increasing operating costs over time.
- Create triggers for cost studies to be repeated, not to exceed a minimum of every 5 years.



Fiscal Impact

- The full fiscal impact is unknown at this point in time given that the cost study and recommendations have not been completed.
- Per Navigant's July 10, 2017 report, page 24, "Rates used in 2007 and proposed 2017 Idaho rates are on the low end of other states' payment rates. Navigant's proposed rates would be more comparable to similar states' rates."
- If the fiscal impact exceeds what the funding available via the Idaho legislative appropriation, providers support a tiered approach to achieving rates that reflect the true cost of service provision and will allow for creation of a stable workforce.



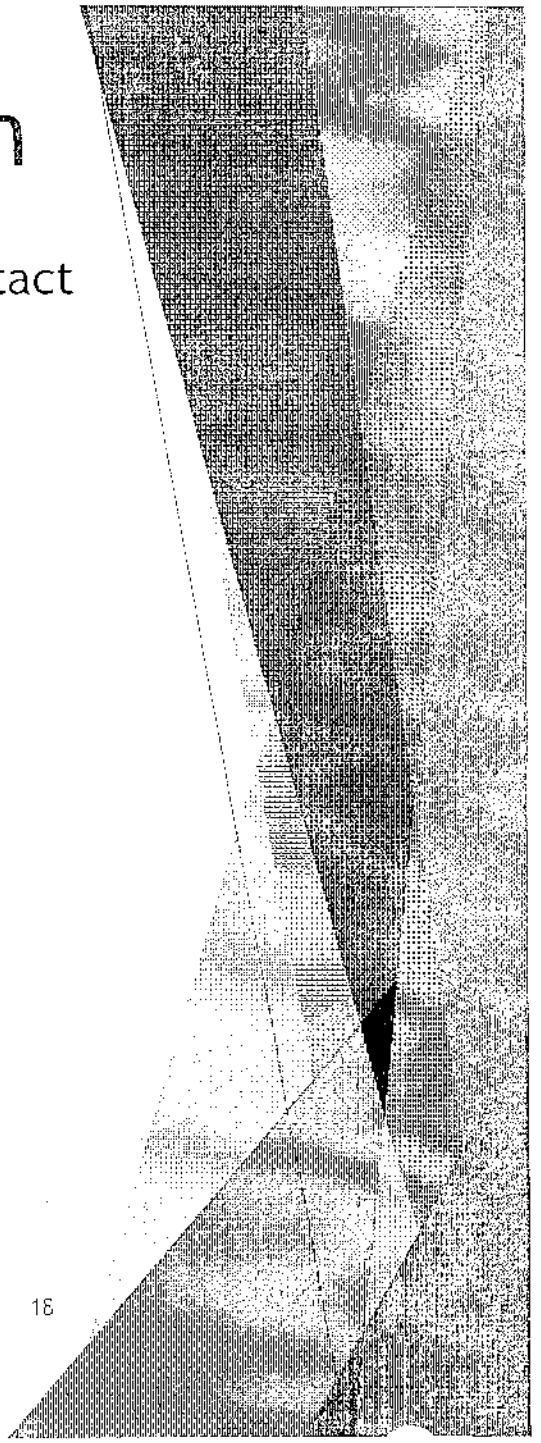
Requested Next Steps

- "The Board is a rulemaking and advisory body that can adopt, amend, or repeal rules and standards of the Department."
- The IACP requests the following from the Board:
  - Hold the Department accountable to **use the Arizona Model** (aka Brick Method) in its entirety for all rate studies associated with IDAPA 16.03.10.037 as originally intended and acknowledged in the Department's communication in writing to Germane Committees by Larry Tisdale and Leslie Clement, supported by providers, and by Navigant's review of the recent study.
  - Hold the Department accountable to **utilize a blend of BLS occupational categories** that accurately capture the responsibilities of a direct support staff and will allow providers to compete with the job market as a whole for employees in order to create a more stable workforce in order to positively impact quality and consistency of services for individuals with developmental disabilities and their families across Idaho.
  - Encourage the **use of temporary rules developed in collaboration with all stakeholders** that will enable Idaho to follow a rate methodology that supports quality, accessible, and sustainable services while maintaining a stable workforce, ensuring transparency and accountability.

Questions or More Information

For more information or if you have questions, please contact the following:

- Becky Novak, IACP President
  - bnovak@clearwater.care
- Shawn Johansson, IACP Vice President
  - shawn.johansson@hasincorporated.com
- Bill Benkula, IACP Legislative Committee Chair
  - bbenkula@hotmail.com
- Michelle Weaver, IACP Member
  - michelle@embassyllc.com



ATTACHMENT 3


IDAHO ASSOCIATION OF COMMUNITY PROVIDERS

IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH - Governor
RICHARD V. ARMSTRONG - Director

DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE (208) 334-5747
FAX (208) 364-1811

November 30, 2006

All Senate Health and Welfare Committee Members
All House Health and Welfare Committee Members
All Joint Finance and Appropriation Committee Members

Dear Committee Member:

Pursuant to the requirements of House Bill 190, passed by the 2005 Idaho Legislature, the Department engaged Johnson, Villegas-Grubbs and Associates LLC (JVGA) to assist in establishing a methodology for reviewing and determining Medicaid reimbursement rates to private businesses providing community-based services. Those included in the community-based services study were mental health clinics, developmental disability agencies, service coordination providers, mental health rehabilitation providers, residential habilitation agencies, independent residential habilitation providers (also known as certified family home providers), and supported employment services providers.

JVGA's proposal to Idaho was to implement the Arizona Model to standardize rate setting and development. The Arizona Model, which is a Staff Support Hour (SSH) rate approach, is designed to establish a fair and equitable process for establishing rates based on actual market costs.

In applying the SSH approach, four standard cost components are assumed to be common to all of the services included in the study. These components are 1) Direct Services Staff Wage, 2) Employment-Related Expenditures, 3) Program-Related Expenditures and 4) General and Administrative Expenditures.

The process began with a series of meetings between JVGA staff and providers. Provider group representatives were invited to voluntarily participate in the rate study. The process and rate setting methodology was explained to the provider representatives at these meetings.

The rate development methodology included a ten-step process:

- Determining and validating the four cost categories
- Gathering financial data from a representative sample of service providers
- Organizing and Analyzing Data so cost components could be compared in a consistent manner across providers
- Reviewing standards to reflect provider qualification levels
- Establishing Direct Service Staff Wage Profile using the Bureau of Labor Statistics to identify prevailing market wages paid by providers in the area
- Determining Employment-Related Expenditures Percentages
- Setting General and Administrative Compensation Level
- Synthesizing Components into Draft Rate including adjustments for acuity
- Performing Budget Impact Analysis and Finalize Rates
- Study rate Impact by Provider

The JVGA report details each of these steps, provides a detailed description of services, and includes provider recommendations to streamline operations.

In addition to the rate study conducted by JVGA, the Department also contracted with EP&P Consulting to conduct a study comparing Idaho rates with rates established in other state Medicaid programs. Neighboring states such as Oregon, Washington and Utah primarily administer their Medicaid programs through managed care organizations and do not have comparable rate structures. Montana, Wyoming, North Dakota, South Dakota and New Mexico were selected as states that have similar demographics and Medicaid programs. Even with these similarities, the consultant found that the differences in the case-mix of clients, provider qualifications and local wages made the comparisons difficult. While inconclusive, it appeared that Idaho was generally found to be in the low to middle range for rates across the study.

The Department will bring the following recommendations before the Health & Welfare Germane Committee for consideration:

1. Adopt Arizona Model as Idaho's reimbursement methodology for reviewing and setting rates on an annual basis. The Department believes that this recommendation provides transparency in the rate setting methodology.
2. Adjust service rates to reflect the conclusions of the analysis that results in a projected budget impact of $4 million. Adjustments reflect both increases and decreases at the service code level.
3. Adjust school based service rates that are currently aligned with private community-based services that results in a projected budget impact of $605,000.

The following table depicts conclusions of the rate analysis by service category.

MENTAL HEALTH CLINICS	$	(1,526,795.12)
REHAB MENTAL HEALTH SERVICES	$	493,440.14
MENTAL HEALTH (Service Coordination for Adults)	$	160,134.38
DEVELOPMENTAL DISABILITY CENTERS	$	(2,505,729.13)
DD CASE MANAGEMENT (Service Coordination for Adults)	$	(94,618.44)
EPSDT (Service Coordination for Children)	$	(231,456.62)
RESIDENTIAL HABILITATION- AGENCY	$	5,720,218.96
RESIDENTIAL HABILITATION -- INDEPENDENT (Certified Family Homes)	$	2,200,959.60
SUPPORTED EMPLOYMENT SERVICES	$	(193,275.82)
SUBTOTAL	$	4,022,877.95
SCHOOL BASED SERVICES EFFECT	$	605,341.77
TOTAL	$	4,628,219.72

To obtain a copy of the consultants' reports, contact Gynna Loper at 208-364-1994, or email at loperg@idhw.state.id.us.

Should you have any questions, please feel free to contact me at 208-364-1812.

Sincerely,

LESLIE M. CLEMENT, Administrator
Division of Medicaid

LMC/sp/ks

Enclosure: rate adjustment at procedure code level

cc: Richard Schultz, Deputy Director of Department of Health & Welfare
Larry Tisdale, Bureau of Financial Operations

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. DUMENIL - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 364-1847
FAX: (208) 364-1811

November 26, 2008

All Senate Health and Welfare Committee Members
All House Health and Welfare Committee Members
All Joint Finance and Appropriation Committee Members

Dear Committee Members and Director Armstrong:

In compliance with the requirements of Idaho House Statute 56-118, the Department engaged Johnson, Villegas-Grubbs and Associates LLC (JVGA) in 2006 and 2007 to help develop and implement a methodology for reviewing and determining Medicaid reimbursement rates for those providing developmental disability and mental health services. These services include those provided by Mental Health Clinics, Developmental Disability Agencies, Service Coordination providers, Mental Health Rehabilitation providers, Behavioral Consultation/Crisis Management providers, Personal Care Services-Case Management providers, Residential Habilitation Agencies, and Independent Residential Habilitation providers (also known as Certified Family Home providers). Supported Employment providers were not included in the list of providers, but they asked to be part of the study after the law was put into place.

To recap from last year's report, JVGA's proposal to Idaho in 2007 was to implement Idaho's version of the reimbursement methodology of the "Arizona Model" to standardize rate setting and development. The Arizona Model, which is a staff support hour (SSH) rate approach, is designed to establish a fair and equitable process for establishing rates based on actual market costs expressed as a relationship to direct service staff wages. There are four standard cost components assumed to be common to all of the services included in the SSH study. These components are:

- Direct Services Staff Wage
- Employment-Related Expenditures
- Program-Related Expenditures and
- General and Administrative Expenditures.

Johnson, Villegas-Grubbs and Associates LLC was not engaged again in 2008 to complete the work on the development of the "Arizona Model" to be implemented in Idaho. In 2008, the Department continued the JVGA work by fine tuning the "Arizona Model" reimbursement methodology and refining the survey data collected in 2007 to adhere to the CMS guidelines that capture employment-related expenditures as they relate to direct services staff wages only. Employment-related expenditures as they relate to non-direct services staff wages was re-allocated to program-related expenditures. The Department asked provider groups to resubmit their survey data to adhere to CMS' request. Also, provider groups requested to submit the cost of direct services staff non-billable time and report that cost as program-related expenditures. The Department accepted the provider's request but voiced a caveat that the categorization of these costs to program-related expenditures will ultimately have to be approved by CMS. Provider group representatives were again invited to voluntarily participate in the rate study.

This year, the Department decided to use the Bureau of Labor Statistics (BLS) wage comparison for Idaho in order to more accurately reflect the wages paid in Idaho instead of using the wage comparison for the entire U.S.A which was done last year. Within the scope of the survey data, it was found that Idaho's providers are currently paying significantly below the mean Bureau of Labor Statistics (BLS) wages for Idaho. The BLS's mean wages are typically used in the "Arizona Model" for calculating provider reimbursement rates. To bring reimbursement up to costs, based on the mean BLS, wages would amount to approximately $22 million dollars.

The Department is currently working with CMS to approve the "Arizona Model" as Idaho's reimbursement methodology. The approval process includes submitting State Plan amendments and waiver amendments to gain federal authority to pay providers the rates which are calculated based on this methodology. Because this approval process takes a great deal of time, the Department has submitted a Decision Unit of $11.6 million dollars to the 2010 Legislature through the Governor's budget request. As a starting point, the Department will increase reimbursement rates closer to the calculated rates based on the new "Arizona Model" reimbursement methodology. Upon final federal approval of the rate setting methodology by CMS, the Department will work with key stakeholders to update the appropriate statute and administrative rules. The Department believes that this recommendation provides transparency in the rate setting methodology.

In addition to the 2008 survey process, the Department updated the Analysis and Rate Comparison Report. This report compares current Idaho rates with rates established in other state Medicaid programs and private health businesses. Neighboring states such as Oregon, Washington, and Utah primarily administer their Medicaid programs through managed care organizations and do not have comparable rate structures. Montana, North Dakota, South Dakota, New Mexico, and Wyoming were selected as states that have similar demographics and Medicaid programs. While having similar demographics and programs, the differences in the case-mix of participants, provider qualifications, and local wages make drawing a conclusion

from the comparisons difficult. That being stated, it appears that Idaho was found to be in the low to middle range for rates again this year.

The Department requested provider cost-savings suggestions to streamline operations in 2006 and 2007. These suggestions are summarized in the JVGA 2006 Report and JVGA 2007 Report.

To obtain a copy of the updated Analysis and Rate Comparison Report, the JVGA 2006 Report, or the JVGA 2007 Report, please contact Judy Russell at (208) 364-1890, or email her at russellj@dhw.idaho.gov.

If you have any questions, please contact me at (208) 287-1141.

Sincerely,

Larry E. Tisdale, Chief
Bureau of Financial Operations

LET/sp

Attachment

cc: Richard Schultz, Deputy Director
Leslie M. Clement, Administrator

IDAHO MEDICAID RESIDENTIAL HABILITATION SERVICES COST SURVEY REVIEW

IDAHO DEPARTMENT OF HEALTH & WELFARE

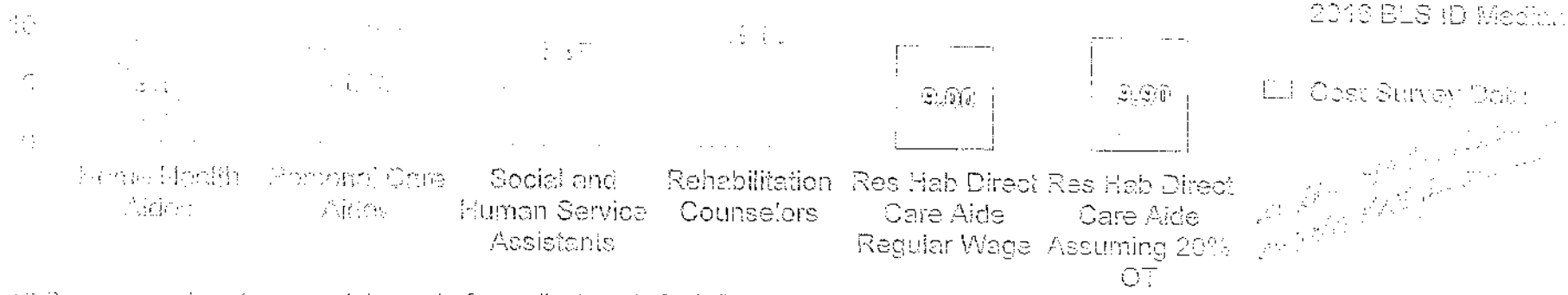
DIRECT CARE STAFF WAGES

Review of Wages used by or proposed in Idaho to date:

	BLS Occupation Title [1]			Wage before Inflation (and date)	Wage Inflated to October 1, 2017*
Selected by DHW	Personal Care Aide (mean)			$10.47 (May 2016)	$10.88
Eleven 8 Group for Cost Survey	N/A			$9.60 (January 2017 midpoint)	$9.79
Proposed by IACP	Home Health Aide (28.5%)	Personal Care Aide (28.5%)	Psychiatric Aide (43%)	$11.57 (May 2016)	$12.30
Idaho's 2007 Wage in Rates	Home Health Aide			$8.68 (2005 BLS)	$11.35

- *2005 BLS wage data inflated assuming 2% annual inflation from May 2005 to May 2016*
- *Other wages inflated using Global Insights Inflation – Employment Cost Indexes – West from May 2016 to October 1, 2017.*

2016 BLS Wages Compared to Cost Survey Data *



* BLS wages and cost survey data are before adjustments for inflation.

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2016 BUREAU OF LABOR STATISTICS

Code	BLS Staff Type	BLS Staff Description	2016 ID Mean Inflated to Oct. 2017	2016 ID Median Inflated to Oct. 2017	Navigant Feedback
[illegible]	Home Health Aides [2]	Provide routine individualized healthcare such as changing bandages and treating wounds, and applying topical medications to the elderly, convalescents, or persons with disabilities at the patient's home or in a care facility. Monitor or report changes in health status. May also provide personal care such as bathing, dressing, and grooming of patient.	$11.34	$10.84	Service description includes assistance with daily living and routine activities the participant is unable to accomplish on his own behalf. The service definition includes significantly more components than just healthcare services as indicated in the definition of Home Health Aides.
[illegible]	Personal Care Aides [3]	Assist the elderly, convalescents, or persons with disabilities with daily living activities at the person's home or in a care facility. Duties performed at a place of residence may include keeping house (making beds, doing laundry, washing dishes) and preparing meals. May provide assistance at non-residential care facilities. May advise families, the elderly, convalescents, and persons with disabilities regarding such things as nutrition, cleanliness, and household activities.	$10.00	$10.50	Service description includes assistance with household tasks and activities that allow individuals to live in their own home which are not included in Home Health Aide.
[illegible]	[illegible] Rehabilitation Counselors [4]	Counsel individuals to maximize the independence and employability of [illegible] personal, social, and vocational difficulties that result from [illegible], illness, disease, accidents, or the stress of daily life. Develop treatment plans for residents of care and treatment facilities. Assess client needs and design and implement rehabilitation programs that may include personal and vocational counseling, training, and job placement.	$23.32	$19.75	Service description includes assistance to participant in at least one of the following: Money Management, ADL, Socialization, Mobility, Behavior shaping. These components are not included in Home Health Aide or Personal Care Aide.
[illegible]	Social and Human Service Assistants [5]	Assist in providing client services in a wide variety of fields, such as psychology, rehabilitation, or social work, including support for families. May assist clients in identifying and obtaining available benefits and social and community services. May assist social workers with developing, organizing, and conducting programs to prevent and resolve problems relevant to substance abuse, human relationships, rehabilitation, or dependent care.	$16.10	$16.57	Service description includes rehabilitation and support for families. Does not focus on assistance or other activities that do not encompass all services provided in the residential habilitation setting.
[illegible]	[illegible] Aides [6]	Assist mentally impaired or emotionally disturbed patients, working under supervision of nursing and medical staff. May assist with daily living activities, lead patients in educational and recreational activities, or accompany patients to and from examinations and treatments. May restrain violent patients. Includes psychiatric orderlies.			Because Direct Care Staff do not work under direction of nursing and medical staff, Navigant does not recommend using this code. Additionally, data is not available on the state level for Idaho.

[illegible] ALL RIGHTS RESERVED [illegible]

SERVICE DESCRIPTION AND STAFF TYPE REVIEW

Service Description according to IDAPA 16.03.10 Section 703
Habilitation services aimed at assisting the individual to acquire, retain, or improve his ability to reside as independently as possible in the community or maintain family unity. Includes one or more of the following: Self-direction, money management, daily living skills, socialization (therapeutic), mobility, behavior shaping.
Personal Assistance Services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the participant or the participant's primary caregiver(s) are unable to accomplish on his own behalf.
Skills training to teach waiver participants, family members, alternative family caregiver(s), or a participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self-direction, money management, socialization, mobility and other therapeutic programs.

DHW Proposed Approach

Occupation Title	Mean Hourly Wage	Department Determine Inflation Factor	Inflated Hour Wage
Personal Care Aide	$10.47	3.76%	$10.86

1) Personal Care Aide does encompass components of the service description, such as assisting with household and housekeeping activities

2) Personal Care Aide does not encompass assisting with habilitative tasks and healthcare tasks

IACP Proposed Approach

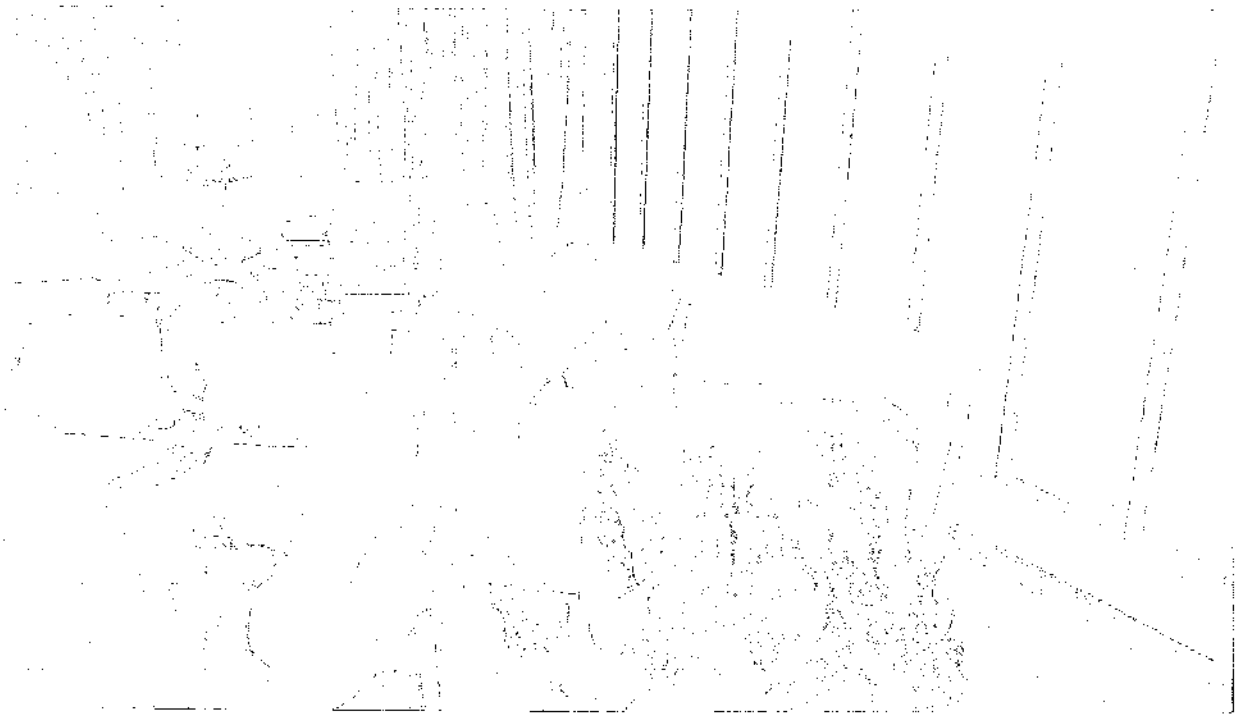
Category	IDAPA Requirements for Supported Living	Home Health Aide	Personal Care Aide	Psychiatric Aide
BLS Wage (based on 2015 BLS data)	** $11.57 recommended wage before Inflation	$10.[illegible]	[illegible]	[illegible]
Weighting*		[illegible]	[illegible]	[illegible]

1) Home Health Aide does encompass a portion of responsibilities of direct care staff

2) Personal Care Aide does encompass components of the service description

3) The BLS description of Psychiatric Aide does not fit direct care staff as they are not under direction of nursing or medical staff

The DHW proposed approach does not cover the habilitation aspect of the service; however we understand that Idaho's Attorney General believes only a single title is allowed under the rules.



Service and Support Recommendations from

[redacted]

Recommendations to the Idaho Department of Health & Welfare, Division of Medicaid

July 14, 2017

Community NOW! proposes the following 17 recommendations to best meet the needs of people with I/DD, and to provide the greatest opportunity for a quality life. Recommendations are grouped into three categories, each relying on the others to be optimally effective. Strategies and techniques to realize these recommendations are discussed in this report below.

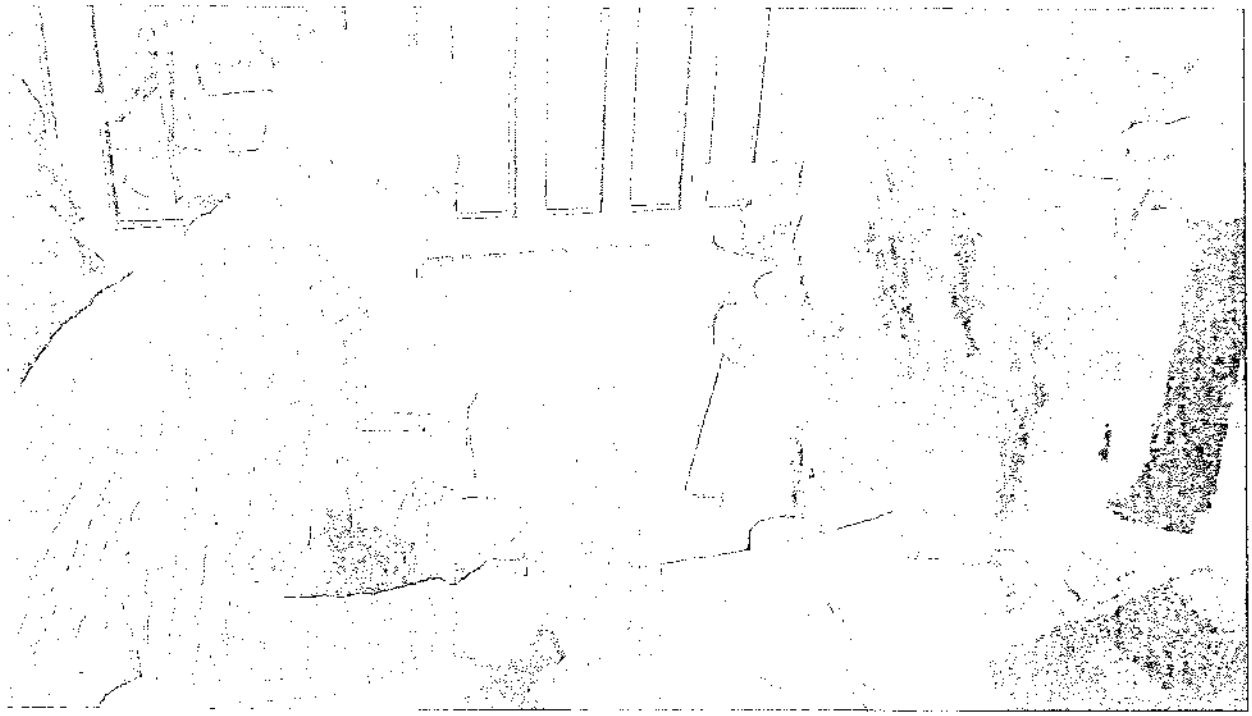
1. Establish a quality Person-Centered Planning (PCP) process based on PCP best practice.
2. Use the Individual Service Plan (ISP) and Support and Spending Plan (SSP) to identify and document how supports (paid and unpaid) are used to achieve the life goals identified in the PCP.
3. Establish an early and ongoing expectation and process to understand, develop, and support the adult's most effective and preferred communication method(s).
4. Take a proactive role in creating and fostering a culture where rights are known, understood, exercised, and respected. This culture should include an emphasis on understanding and using supported decision-making processes to help adults make informed choices.
5. Emphasize and enforce HCBS rules related to adults determining where they live, who they live with, and who provides their support.

6. Create a non-medical service model to support adults with I/DD to meet their needs and explore their interests in their communities over their lifetimes. Provide flexibility within the service array so services can be matched to meet those needs.
7. Provide services that appropriately support adults' overall health, including mental health and substance use.
8. Provide services that appropriately meet the needs of adults with dual diagnosis (mental health and I/DD).
9. Include pre-vocational, career planning, and individual supported employment services in the Medicaid benefits package to support the adult to gain and maintain his or her preferred job in the community at, or above, the prevailing wage.
10. Put mechanisms in place that help adults to find, support, and keep competent, consistent, capable, and quality staff.
11. Implement a tiered, linguistically and culturally appropriate, training process that is standardized and person-specific to ensure that all staff draw from best practice, experience, and knowledge.

12. Address and resolve issues associated with transitions in all phases of life.
13. Provide a mechanism to ensure that information about an adult follows them through systems, providers, and services in a manner that is used on the adult's behalf.
14. Provide consistent and effective supports for adults and families through coordination and communication across all relevant state agencies and schools.

15. Use the goals identified in the individual adult's PCP as the ultimate measure of program effectiveness.
16. Formalize QA processes and implement on an ongoing basis. Use these to assess program effectiveness and to identify and implement improvement strategies.

17. Develop ways to more systematically engage in the following areas on behalf of the adults with intellectual and developmental disabilities:
    - Financial Limitations
    - Guardianship
    - Housing
    - Medical and Non-Medical Transportation
    - Other Medicaid Benefits
    - Post-Secondary Education



a. The plan connects the life goals identified by the adult in the PCP process, including employment (and how employment may affect disability benefits).
b. The plan will identify both paid and unpaid supports that are relevant to the adult's goals. Care must be taken to ensure the paid supports don't drive the plan. Life goals, as outlined in the PCP, should drive the plan. This includes giving TSCs the flexibility to pursue opportunities, including activities outside of paid supports, that may support a person's life goal.
c. Objectives within a plan tie to a goal in a way that is meaningful to the person. If the objective proves ineffective in achieving the goal, a new objective will take its place.
d. The plan provides evidence that the adult will have the opportunity to practice and share their identified strengths.
e. Limit skill building requirements to skills the adult wishes to obtain.
f. The plan and related information is provided to the adult in a way that is understandable to them. This includes providing access to the full list of available Medicaid waiver services to allow for fully-informed choice.
g. Make supports available to aid adults in pursing academic and life-enhancing opportunities.
h. Risk is understood and addressed as a normal part of a person's life and learning experience. Limitations based on risk are narrowly defined and regularly reevaluated, with an understanding that people can learn and grow, impacting the scope of those limitations.
i. The PCP meeting includes a dedicated and meaningful discussion of rights.
j. Quality assurance is tied to the adult's personal goals. Focus is on determining that the services and supports are helping the person achieve what is important to them.

3. Establish an early and ongoing expectation and process to understand, develop, and support the adult's most effective and preferred communication method(s). Attention to communication must start at the earliest possible age and be integrated and maintained within any planning, support, or service provided. Techniques include the following:

a. Provide adults the ability to try different methods of communication. Possible need for a different communication, including assistive technology, must be assessed. If a need exists, the ISP/SSP should reflect and address that need.
b. Recognize that all behavior is communication. Assist providers and those who work with adults to understand this fact and find ways to foster effective communication with the adults they support.
c. Service provision should include paid staff time to review and understand the person's history and communication. Increase capacity for effective communication through training programs, quality assurance practices, and the development and sharing of family and adult expertise of the adult's story.

- Time, distance, and programmatic requirements also limit the community locations and activities accessed during DDA hours.
- Adults with I/DD are often given minimal, if any, information, on how to find, develop, and maintain healthy relationships (romantic or otherwise).
- Transportation is a significant barrier to many community activities, including work.
- There is inadequate training and support for the unique needs of adults with I/DD and mental health support needs.
- Obtaining employment is often based on the connections you have. Many adults with I/DD have very narrow social networks to pull from.
- Employment supports, provided in the workplace, are often poorly-matched to the person's specific needs. This could be a failure by providers to appropriately fade supports, a propensity to do the job for the person, or failing to help the person build their own connections with co-workers.
- Good staff may have innate qualities that make them better at their jobs than others. These qualities cannot always be taught or measured, and it can be difficult to compensate for those traits.
- There is high staff turnover. Staff receive training and leave. Particularly for adults with complex medical or behavioral support needs, turnover is more than an inconvenience-- it is a safety issue.
- For adults who use means other than words to communicate, the process of building understanding with new staff can be lengthy and frustrating. In the interim, these adults face not being understood.
- Many adults with I/DD have aging family caregivers and have not had conversations about what happens after their current caregiver is gone.
- Information about transitions in people's services is hard to obtain. Even when information is available, the process is disjointed, and can leave people without adequate support.
- The various systems that impact adults with I/DD often fail to coordinate and leave adults unable to determine where they should go for the support they are looking for, or confused about why the available supports do not align.

Recommendations for fostering meaningful access to the community.

5. Create a non-medical service model to support adults with I/DD to meet their needs and explore their interests in their communities over their lifetimes. Provide flexibility within the service array so services can be matched to meet these needs. The following strategies support such a model:

    a. Provide additional flexibility for people to do activities in the community. This should include additional individual adult (versus group) support hours, support outside of set-DDA hours, etc.

b. Clear existing mileage allowance limits to foster flexibility on a case-by-case basis, particularly for rural areas, to allow for greater community access. An adult's community may be 30 miles away or more depending on where they live.
c. Find ways to foster additional opportunities for adults to gather with each other organically in their communities. For many, DDAs provide the only opportunity to see friends and be social.
d. Create and promote services that expand community connections outside of paid supports, like a service which identifies others in the community who have similar interests, not just disability-specific. Services might include:

    i. Introducing adults and providers to the variety of community resources, activities, and opportunities available.
    ii. Identifying ways to modify existing opportunities to make them more accessible to adults using services.
    iii. Gathering information.
    iv. Resource pooling.

e. Support the development of peer groups for adults to discuss issues around relationships with each other.
f. Obtain and/or create and make available a curriculum specifically for adults to learn about creating and maintaining healthy relationships.
g. Include mechanisms to encourage coordination across provider agencies that help adults connect with other adults using services.

7. Provide services that appropriately support adults' overall health, including mental health and substance use.

    a. Provide adults the option to have a paid support person of their choice available to them while in a medical hospital.
    b. Provide a mechanism to ensure the effective transfer of information between the adult, service providers, direct care staff, and medical or mental health professionals.
    c. Provide access to substance use treatment.
    d. Increase education and understanding by adults with I/DD, families, guardians, targeted service coordinators, support brokers, and plan developers about what types of medical needs (such as glasses, hearing aides, AFOS, etc.) can and should be appropriately paid for through an adult's budget versus via their medical card. This includes increasing understanding of the differences between specialized medical equipment, durable medical equipment, and assistive technology.
    e. Increase integration between the Medicaid waiver services team and durable medical equipment team to clarify and identify how to best support adults with I/DD in getting their medical needs met. *[added by Community Now! subgroup]*

8. Provide services that appropriately meet the needs of adults with dual diagnosis (mental health and I/DD)

   a. Provide adults the option to have a paid support person of their choice with them when in a psychiatric hospital.
   b. Find a way to adjust traditional practices, such as one-hour sessions with mental health counselors, to accommodate the communication needs of adults, such as providing for two-hour sessions.
   c. Restore Community-Based Rehabilitation Services (CBRS) and bridge the gap between CBRS and traditional services.
   d. Make therapeutic mental health interventions an acceptable service.
   e. Create capacity of providers to serve adults with a dual diagnosis through the National Association of Dual Diagnosis (NADD) certified provider training.
   f. Create capacity for direct service providers to provide trauma-informed care.
   g. Generate a systemic method to transfer mental health information (treatment modalities, medication, coping skills) to appropriate staff.
   h. Assist mental health providers to obtain skills to effectively communicate with adults with developmental disabilities who may have significant cognitive disabilities or communication impairments.
   i. Eliminate the practice of authorizing Mental Health Supports based on IQ Score.

9. Include pre-vocational, career planning, and individual supported employment services (as described in the Idaho Employment First Consortium (IEFC) recommendations [*Appendix A*]) in the Medicaid benefits package to support the adult to gain and maintain his or her preferred job in the community at, or above, the prevailing wage. Strategies to achieve this outcome include the following:

   a. Provide support, learning and work experiences where the adult can develop general strengths and build the skills necessary to perform work. These services should be focused and time-limited.
   b. Help an adult identify a career direction and develop a plan for achieving competitive, integrated, desired employment. The outcome of this service is documentation of the adult's career objectives and a career plan used to guide additional employment support. Support includes the following: planning time and support for experiential learning opportunities and appropriate exploration activities; support to engage in assessment and discovery processes to learn about career options; and benefits planning and consultation.
   c. Provide ongoing assistance to adults who, because of their disabilities, need intensive on-going support to obtain and maintain a job that meets their personal and career goals. This can include customized or self-employment support.

d. Support the addition of opportunities in the adult service system for short-term job experiences.
e. Promote understanding that the primary function of a job coach is to understand the adult's communication methods, assist the adult in building relationships in work settings, and phase-out their support as appropriate.
f. Establish quality assurance measures related to job coaching to provide additional focus on success on the job, and appropriate fading of supports.
g. Establish state-required training that meets ACRE certification for employment support professionals providing career planning and individualized supported employment services. Include nationally identified certification (see detail of IEFC recommendations [*Appendix A*]).

10. Put mechanisms in place that help adults to find, support, and keep competent, consistent, capable, and quality staff. Potential strategies include the following:

a. Support ways for direct support staff to have a competitive wage, benefits, adequate training, and career growth within the role of direct support. Develop mechanisms to make this possible, including assurances that higher rates are passed on by way of compensation to the direct care provider.
b. Create mechanisms that help staff succeed. Staff must have important basic knowledge from the beginning about the person they will be supporting. Create opportunities and expectations for information about the person's communication style, areas of support needs, and preferences to be shared with new staff immediately. Information could be shared by the person receiving support themselves, family, a trusted staff person, etc.
c. Increase provider qualifications requirements for employment support professionals to include specific training and certification aligned with best practice and national standards.
d. Create ways for adults and family members to have direct influence on incentivizing the long-term and continued employment of quality staff.

11. Implement a tiered, linguistically and culturally appropriate, training process that is standardized and person-specific, to ensure that all staff draws from best practice, experience, and knowledge. Strategies for generating such a process include the following:

Standardized training:

a. Adopt a standardized training curriculum for direct support professionals. One option would be training from the National Association of Direct Support Professionals (NADSP) or other curriculums. Additional, standardized, Ohio specific training should be provided by Medicaid.

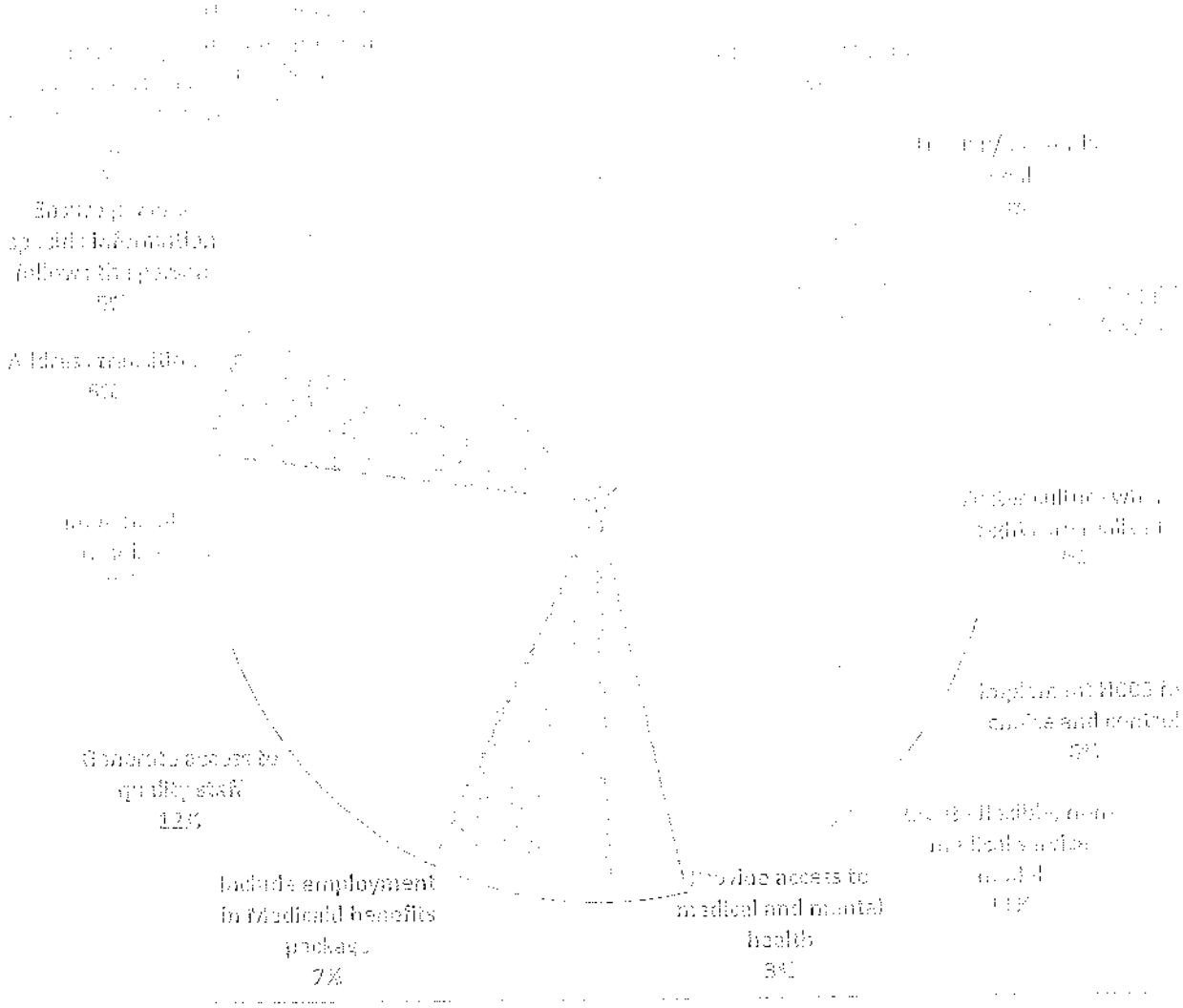
b. Support the development of a training curriculum for staff to be provided by paid self-advocates. This could be specific to the concepts of self-direction, rights, thinking outside of the box when providing support, appropriate language, etc.
c. Encourage and facilitate use of passive training techniques for staff. For example, fridge magnets with rights information, videos with adults talking about rights, etc., opportunities presented within typical daily activities to engage in conversation about rights that make the right relevant.
d. Require additional education and training for Support Brokers and Targeted Service Coordinators on how to be more effective independent advocates.
e. Make available additional and more wide-ranging training opportunities for CFII providers, Supported Living providers, direct care staff, and providers serving adults through the self-direction program.
f. Make training available specifically geared to the competencies needed by employment support providers. This training should include the appropriate methods to fade employment supports over time.
g. Encourage mentoring opportunities between agencies regarding best practices for supporting adults with I/DD.
h. Provide training in, and perpetuate the use of, person-first language in all parts of the delivery system.

Person-Specific training:

i. Encourage the person receiving services, and their friends and/or family members, to be integral in the process of educating staff. This should not be limited to those who select self-direction.
j. Work alongside adults receiving supports to develop staff training curriculums based on the person's specific support needs and preferences.
k. On-going and specific training on the needs of each adult should be required and supported.
l. Train staff to know that they are working for the person receiving support, and expect staff to become experts in asking their permission and respecting their responses.
m. Measure the effectiveness of the person-specific training that staff receive on a regular basis (providing for a shortened feedback loop to maximize effectiveness). Measures, such as testing over time, should involve the person being served whenever possible.

12. Address and resolve issues associated with transitions in all phases of life. Such transitions include: the time between 16 and 21, changes in living situations, changes in levels or types of support (nursing homes, hospital, ICF/IDD, community), moving from children's to adult services, transitions on and off of services, change of guardianship, the death of a family member, etc. Strategies include the following:

SCOPE WORK BY TOPIC



December 21, 2016

Matt Wimmer
Deputy Administrator
Division of Medicaid
Idaho Department of Health and Welfare
3232 Elder Street
Boise, ID 83705

Re: Comparison of IDAPA requirements of multiple potential BLS Occupational Categories

Dear Mr. Wimmer,

In several meetings that have occurred since December 2015, the Department has insisted that the BLS Occupational Category of Personal Care Aide most clearly represents the rule required services and expected outcomes of supported living. The Idaho Association of Community Providers (IACP) has consistently refuted this assertion and finds that there are no grounds founded in rule to conclusively support this category. The Department has conceded that there is not one occupational category that conclusively meets all the requirements of the services in question. The IACP similarly agrees that there is not one BLS Occupational Category that accurately summarizes all the requirements put forth in IDAPA.

Per request of the Department and IACP, representatives of the Bureau of Labor Statistics reviewed the IDAPA rules that outline the responsibilities of direct care staff delivering Supported Living services and made a recommendation on the BLS occupational category(s) which most closely align with the duties and activities of Supported Living direct care staff (i.e. Direct Support Professional). In an email dated December 9, 2016 BLS Lead Economist Theresa Cosca stated the following regarding the duties and activities of Supported Living direct care staff (i.e. Direct Support Professionals) and the BLS occupational categories that align with the staff role:

> *"given additional information regarding specific activities of workers with a job title such as 'direct support professionals' it is possible that these workers could be coded elsewhere including **31-1013 Psychiatric Aides** and **39-9021 Personal Care Aides,** in addition to **31-1011 Home Health Aides**. It is up to customers using the SOC for non-statistical purposes, who will have considerably more information than was provided to BLS, to review the various detailed definitions for the SOC codes and determine which best matches the work being performed by the individual being coded, in light of their own program and policy purposes."*

Bureau of Labor Statistics Classification Principles and Coding Guidelines, 2010 SOC state, and Theresa Cosca confirms in the above stated email, the following:

1) BLS Classification Principle 1 states that "Each occupation is assigned to only one occupational category at the lowest level of the classification."
2) BLS Classification Principle 2 states that "**Occupations are classified based on work performed** and, in some cases, on the skills, education, and/or training needed to perform the work at a competent level."
3) BLS Coding Guideline 2 states that "When workers in a single job could be coded in more than one occupation, they should be coded in the occupation that requires the highest level of skill. If there is no measurable difference in skill requirements, **workers should be coded in the occupation in which they spend the most time**."

The attached table captures the differences between the BLS recommended occupations of Home Health Aide, Personal Care Aide, Psychiatric Aide, and Supported Living Services direct care staff. As noted in the attached table, while all three categories capture elements of the Supported Living direct care staff role, the occupation which most closely aligns with the responsibilities of direct care staff is Psychiatric Aide. In keeping with BLS Principle #2, this category should be chosen as the basis for determining the direct care staff wage in the rate calculation. IACP is formally requesting use of the category in determining future reimbursement rates for Supported Living services.

If the Department finds this recommendation unsatisfactory, IACP would be open to considering a blend of the 3 occupations at the following weights based on match to responsibilities as captured in the table:

- Psychiatric Aide 43%
- Home Health Aide 28.5%
- Personal Care Aid 28.5%

The resultant wage based on this weighting is $11.57 prior to inflation.

In addition to those responsibilities that align with Psychiatric Aide, Home Health Aide, and Personal Care Aide, Supported Living direct care staff are required to provide skills training and behavior management/shaping, which is a duty above and beyond any of the other categories and should serve as the impetus for a wage basis at or above these three categories.

As a provider association, we continue to urge the Department to take into account the consistent input and feedback providers have given regarding the wage basis throughout the rate study process that to date has been ignored. As providers, we are intimately familiar with the day to day duties of providing supported living services. Our recommendations are now also supported by the response from the Bureau of Labor Statistics following their review of IDAPA rules for Supported Living services.

We formally request that the Department's basis for direct care wages accurately capture the responsibilities of the position as well as lead to a wage rate that will allow providers to recruit and retain adequate staff who can carry out the required responsibilities of the job.

On behalf of Idaho Association of Community Providers,

Shaun Bills,	Becky Novak	Bill Benkula
IACP President	IACP Vice-President	Immediate Past President

December 23, 2016

To: Idaho Association of Community Providers
4477 W. Emerald STE C100
Boise, Idaho 83706

Attention: Shaun Bills, IACP President

Re: Review of Draft Report: "Supported Living Services, Residential Habilitation"
October, 2016, Myers and Stauffer

From: John Villegas-Grubbs MBA, MC
Principal

We have reviewed the report referenced above and the related rule (Idaho Administrative Code IDAPA 16.03.10 and in particular section 037 General Reimbursement) and have the following for you to consider:

General Comments

Introduction: JVGA completed a rate development project in Idaho in 2007 in which the architecture of rate development that was then referred to as "The Arizona Model" (now referred to as the Brick Method™) was used. This method proceeds from the identification of cost components and utilizes them to construct a fully loaded hour of direct supports. The method establishes the Direct Staff wage using the Bureau of Labor Statistics (BLS). The four basic cost components in this system are: Direct Care Wage, Employment Related Expenditures, Program Related Costs, and General & Administrative (sometimes referred to as one of the indirect cost categories). The actual number and identity of the cost components vary by service and by state. These cost components are present in and the use is required by the Administrative Code referenced above. For purposes of this review we compared the approach used by Myers and Stauffer to the approach which resulted in the structure present in rule.

Approach: While JVGA does not utilize cost surveys and prefers to work directly from General Ledger reports the use of surveys is instructed in Idaho Administrative Code.

The original architecture (Arizona Model / Brick Method™) proceeds by fully predicating all the components in the rate system (and in Idaho Administrative Code) on the Direct Care Staff hour as the central basis of the true costs of providing these services.

We noted from the Myers and Stauffer report that the Direct Care Staff Wage and Employment Related Expenditures were driven from BLS data and appear to be based on the hour of Direct Care Staff time. However, the other components (Program Related Costs and General & Administrative Costs) appear to be predicated on what Myers and Stauffer refer to as a "Normalized Unit." According to the report, this is derived from the units present in the Medicaid data management protocols (MMIS), not the hour of direct care supports. The units of time captured in the MMIS system are billable events and represent the time encountered by the consumer, not the support staff. The consequence of this approach, in our opinion, is that the actual valuation presented as the basis of the Myers and Stauffer study is of a unit that combines parts of two separate and distinct *kinds* of units (staff hour / hour of consumer time) into a hybrid unit that does not actually exist. The effect is to render any analysis of the adequacy or efficacy of the valuation impossible. It also results in having to conclude that any assumptions about the fairness or equity of the resulting rate system would be unreliable.

We also noted that the formula used to arrive at the "Intense" and "Intense School Based" daily rates appears to be exactly half of that for the "High and High School Based" daily rates, but could find no explanation for this valuation. The approach to divide the daily rates for "High and High School Based" appears to be without any objective basis.

We reviewed the possible selections of Direct Care Staff personnel to arrive at what we believe would be a reasonable option to use to establish the Direct Care Staff wage. The central issue in this part of the development is whether or not there is indication of the need to perform habilitation, because the service itself is habilitative in nature. Present in the Idaho Administrative Code is a requirement that if the BLS data does not contain a reasonable selection option for direct care staff wages that a weighted average of wages be adopted (Section 037.04). Representatives from your organization (the Idaho Association of Community Providers), working with the Bureau of Labor Statistics, performed an analysis of a variety of different job descriptions and weighted them in order to blend to a single hourly wage equivalent, in order to compensate for the weakness in the use of any single job category. We (JVGA) reviewed the process and their assumptions and found them to be extremely well thought-out and the approach very reasonable.

The report presented by Myers and Stauffer does reference the advent of the Affordable Care Act (ACA) as a possible unfunded mandate but cites that there is insufficient date to support the addition of potential expenditures in the Employment Related Expenditures component of the valuation of the hour.

There is no indication that a similar unfunded mandate, that of a change to the regulations associated with the use of salaried employees and the requirement for payment of over-time charges, be considered.

JVGA Recommendations:

1. Because the use of surveys is directed in rule, we make no recommendation as to the use of general ledger reports.
2. We recommend that the state consider revising the structure of the development of the value of the hour to be fully predicated on the direct support hour (Direct Care Staff) and not bifurcated between that measurement of time and the "Normalized Unit".
3. We recommend that the state consider adopting a wage based on the average of the three potential job descriptions cited in the BLS data and present in the IACP document "BLS Occupational Category Skills and Outcomes Weighting" for the following reasons :

   No available job description is complete as regards the requirement of habilitative outcomes as the central distinction in the service being quantified, and,

   No data upon which a weighted average of wages can be calculated exists within the BLS data sets.

   The wage that was calculated by the IACP members and referenced above in "BLS Occupational Category Skills and Outcomes Weighting" is: **$11.57**

   During the last four years JVGA was engaged to prepare a proposed rate system using the Brick Method™ for the States of North Dakota, New York, and New Jersey. It bears citing the wage levels for these three environments because the services are essentially identical (Residential and Day Habilitation) and the standards driving staff qualifications are essentially the same. They are, in reverse chronological order:

   North Dakota (2014): The wage adopted for the study for North Dakota was $15.25. This wage level was driven by existing legislation and not the BLS.

   New York (2014): The BLS wage ranges for the relevant job categories JVGA reviewed was $10.27 - $13.24 (unadjusted for inflation).

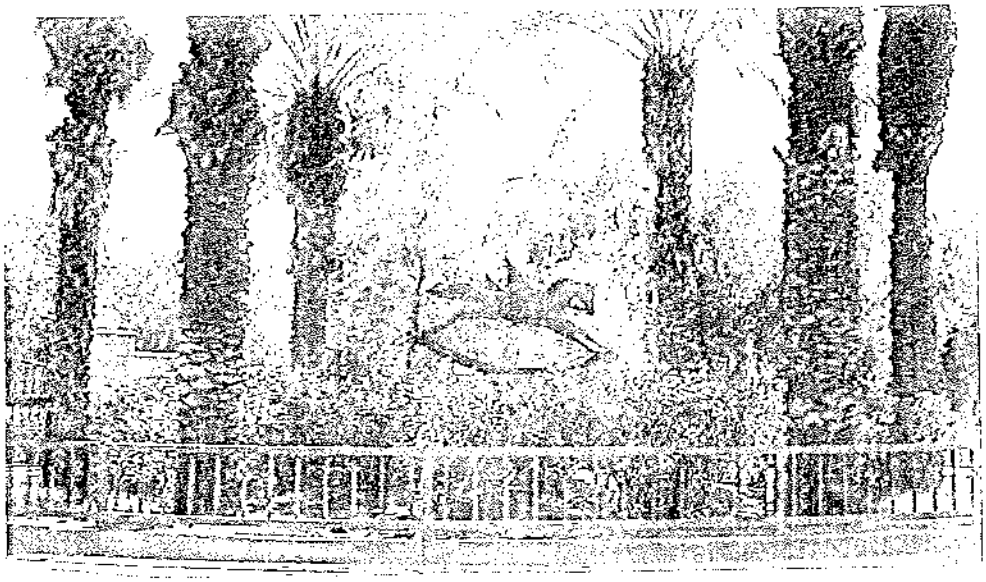
   New Jersey (2015): The BLS wage for the relevant category selected for use was $13.15 (unadjusted for inflation). It is our understanding that as the

state is waiting for approval of the waiver they have adjusted the JVGA base wage to **$14.30** to reflect the Consumer Price Index for the year of implementation.

Thank you for the opportunity to have performed this review and it is our sincere hope that the issues related to appropriate funding for these services can be resolved to the satisfaction of the state, the providers of these services, and most importantly to the people who need and use these services and their families.

ATTACHMENT 4

Johnston, Villegas-Grubbs and Associates LLC



FINAL REPORT

A REVIEW AND RECOMMENDATION FOR STANDARDIZED RATES FOR MEDICAID COVERED SERVICES

Submitted to the State of Idaho, Department of Health and Welfare

Release Date: November 30, 2006

Cover Photo

The winged rocking horse in the cover photo is a statue at the entrance to an island in Encanto Park in Phoenix, Arizona where there are rides and amusements for children. Its presence there speaks to the limitless imagination of children.

Table of Contents

Chapter 1: Executive Summary

In the spring of 2006 Johnston, Villegas-Grubbs and Associates LLC (JVGA) was selected to lead a project in which the rates for Idaho's Medicaid Services would be reviewed. The purpose of the project has been to analyze the rates and the service delivery system and to make recommendations in a series of proposed standardized rate revisions.

The JVGA team attempted to learn as much as possible about the services in Idaho before approaching the rate analysis.

The first component of the project involved a series of meetings between JVGA staff and providers in three category areas: Residential, Day Programs, and Mental Health Services. Case Management rates were reviewed and revisions proposed. Certified Family Homes were also reviewed separately.

The State of Idaho is to be commended on several points. First, the relationship between the State Medicaid Office and the provider community in general is very positive. There was a characteristic of cooperation during the project that rendered the information much more accurate and complete than it would have otherwise been.

The JVGA team was also impressed with the development of Community Crisis Support. The State has been able to integrate this very important service into other existing services so that the availability of crisis support is much more readily available to the individual in need. Other programs in the country are struggling to solve this kind of problem, where Idaho seems to have crafted and implemented the solution already.

Another interesting characteristic of services in Idaho is the integration of therapies into the day programs, for people with Developmental Disabilities. There is an efficiency in this, as regards the lives of the people being served, in that they receive these supports as part of their daily routine. While it is an excellent way of supporting people in need, JVGA found that it could be difficult to structure the compensation for the Day Service in a way that would adequately capture the therapeutic costs that are related to the day program (as distinct from compensating them as separate therapy services).

Mental heath services appear to be well integrated between in-clinic services and those in the community. JVGA staff accompanied one of the Counselors in the mental health services delivery system, with permission of the client. The JVGA staff member (who is also a Mental Health practitioner) was again impressed with the quality of services that were being provided, as evidenced by the session that was observed. The life circumstances of the person being served were addressed holistically, and the community support activities and mental health counseling appear to be seamlessly integrated. Again, this quality of service places an increased pressure on the analysis to arrive at appropriate compensation such as not to leave out the ancillary program related costs.

JVGA conducted a series of interviews with one of the Certified Family Homes, culminating in a three-hour conference call with five other family homes included. The dedication and selfless service that these individuals exhibit cannot be overstated. Like many of the other services, the danger in setting compensation levels lay in the accurate analysis of peripheral program supports. In the case of Certified Family Homes, the problem is not in the expense of professional supports (such as with day programs) or with the integration of several different kinds of supports (as with mental health providers). The problem is in the fact that the every day activities of life that people without disabilities are able to take for granted, are far more difficult and often more expensive in cases of people with developmental disabilities.

The second phase of the project involved gathering financial data and analyzing the data in a way that lends itself to the use of a direct care driven rate structure. The rate structure that JVGA uses for long-term care is commonly referred to as "The Arizona Model". More information about the model is presented in ***Chapter Three: "Methodology"***.

The third and final phase of the project was the construction of the rates, and the comparison of the proposed rates to those currently being paid.

Again, the State of Idaho is to be commended in several areas. It is always difficult to take on the task of setting compensation levels for services that so critically affect peoples' lives. This becomes much more pressing when the services are well integrated and creatively provided by caring, responsible individuals. Such is the case in the State of Idaho.

Chapter 2: Background

Overview

According to the recent report on the Real Choice Systems Change grant in Idaho:

> Idaho was a relatively early adopter of the HCBS waiver process as a means of controlling Medicaid costs and leveraging Federal matching funds to reduce control of the rise in state spending. Moving patients from state- funded facilities such as state hospitals and Idaho state schools and hospitals to community facilities means that Medicaid's Federal match pays for a large part of the care that was previously paid entirely from state funds. In 2004, the Federal Medical Assistance Percentage (FMAP) for Idaho was 73.9%. This includes a 2.95% temporary increase from a Congressional appropriation aimed at state fiscal relief. The FMAP will be 70% in 2005. Leveraging the FMAP though HCBS waivers has had at least two major effects: **(1) HCBS have expanded greatly in a brief period of time; and (2) spending on long-term care has grown faster for HCBS services than for institutional care over the past five years. . . .**
>
> While growth in total expenditure for Medicaid was relatively stable over the last few years, following the state's population growth and recent economic downturn, changes in the distribution of Medicaid expenditures for long-term care was dramatic. In addition, the Kaiser Family Foundation, in a recent analysis, reported that in 2002 Idaho's Medicaid program spent about 75% of its funds on care elder, blind, and disabled care while these populations accounted for about 24% of the beneficiary population. (12) **The relatively high per capita cost for elder and disabled care provided an immediate and sustained incentive for cost-containment.** As the population ages this imperative becomes more urgent. . . These services have proved to be good alternatives to traditional institutional services. Their rapid growth indicates that they are close substitutes for institutional care and they can provide services at a lower unit cost to a large range of the disabled and the elder population.[1]

Results from a 2002 Study of Supported Living Services[2]

The Idaho Council on Developmental Disabilities funded a study of Supported Living, which was conducted Allen, Shea & Associates, and noted the following issues with rate setting:

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[1] [illegible]

[2] [illegible]

Most individuals we talked and material reviewed seems to have something to say about rates. For example, the Olmstead planning group recommended raising the HCBS/ISSH cost effectiveness cap to allow waiver participants to use supported living without a roommate when their needs require a higher cost effectiveness cap.

In regards fund flexibility, the group indicated that Medicaid billing requirements for community living are burdensome and tied to rigid categories. For example, supported living placements rely on a combination of discrete waiver services, which must be performed, documented and billed in units as small as fifteen minutes. Care and supervision for a person may require a provider to switch from one service to another many times each day depending on the activities.

They recommended that bundling of services into a single daily rate or billing code and simplifying documentation requirements. This could save considerable time and expense, making it easier for supported living providers to serve more consumers and meet more diverse needs.

When asked what it would take for an agency to start offering supported living services, one provider indicated that the process of developing individual supports and a service contract would need to look like the following:

- an individual selects a provider;
- the individual (and others in the individual's circle of support) and the service coordinator describe a preferred lifestyle to the provider (e.g., characteristics of a home, with or without housemates, what a typical day and weekend would look like, hopes and dreams, goals for greater independence);
- the provider develops a service plan and an individual budget and suggests ways to support the person (e.g., type and frequency of support staff);
- the individual budget is negotiated with the individual and service coordinator and a service contract is established by the Access Unit.

Another individual reiterated the above by suggesting that rates and reimbursement procedures should be simplified such that one could sit down with the person and those who know them well, work up a reasonable plan, designed to provide a decent and preferred lifestyle, negotiate costs and services, add up the costs and an individual budget is created.

When asked about current rates and funding structures, another individual suggested that Idaho has created a system that requires providers and individuals to justify every 15 minutes of 'billable' time. Those 15 minutes blocks must be linked, documented to a specific goal and rates. Also, providers appear to have used developmental therapy as a means to make up for the low residential habilitation rates. Individuals, therefore, may be forced to develop and work on goals that are undesired or useless. The bottom line is that it looks like 'make' work has been created to justify a payment.

As previously noted, in order to make the low rate for residential habilitation work for providers, we were told that a 'package' including developmental therapy and behavioral services is typically provided to individuals. As we have also indicated, this package by its nature excludes individuals who may need less than 24 hour a day support. Using the example of the SLS agency in Napa for comparison sake, the range of monthly reimbursement for individuals supported is from $450 to $8, 285. For a similar agency in Idaho, the monthly range is reported to be from $5,800 to over $10,000.

Finally, the service 'package' as it has developed now typically includes three to five separate contracts between the provider and the State. In addition to multiple monthly claims, each contract includes an annual audit and monitoring review. This replication of effort creates a significant cost to both the State and the provider.

Rate review and report requirements

The 2005 Idaho Legislature, under HB 190, made changes to Title 56, Chapter 118, Idaho Code, establishing a "fair and equitable" process for reviewing Medicaid reimbursement rates and participant access to services, and making requirements for an annual report for the Department of Health and Welfare and the Legislature. Specifically, the law required the Department to "implement a methodology for reviewing and determining reimbursement rates to private businesses providing developmental disability agency services, mental health services, service coordination and case management services, residential habilitation agency services and affiliated residential habilitation specialized family home services annually." The law also required the Department to consider the following information in the report to the Legislature:

- The actual costs of providing quality services, including personnel and total operating expenses, directly related to providing such services;
- Changes in the expectations placed on private business providers in delivering services;
- Inflationary effects on the private business providers' ability to deliver the service since the last adjustment to the rate;
- Comparison of rates paid in neighboring states for comparable services;
- Comparison of any rates paid for comparable services in other public or private capacities;
- Estimated costs of implementation based on the current caseload forecasts; and,
- Cost saving suggestions provided by private businesses.

Chapter 3: Methodology

Brief history of the Arizona Model

John Villegas-Grubbs (then Chief Financial Officer of the Arizona Division of Developmental Disabilities) originally designed this system in 1997, in response to a crisis in negotiated rates for those services. At that time, thousands of rates existed in Arizona for the same service, but were not responsive to the needs of individuals. The proliferation of rates was related to the passage of time, the entrance of new providers, and the advent of new clients entering the system. Identical circumstances could exist for two individuals for whom the rates for services were widely divergent.

The system was developed over a period of two years, and was piloted in 1998 with 15 agencies. It was then reviewed and determined actuarially sound in 1998. In the year 2000, the District of Columbia expressed an interest in the system and it was adapted and applied to Community Residential Facilities. By 2003, the system had also been adapted for ICFs-MR in the District and was made public in July of 2003.

During this same period, the State of Delaware began the development of their Direct Care Staff driven model (a modification of the Arizona System), which was fully implemented in 2005. The State of Florida also began a reform initiative in 2003, which included the development of this system for their Developmental Disabilities community-based waiver. The Florida rates were finalized in the summer of 2003 and implementation has been completed.

During the fall of 2003, the rate system was also adapted to apply to community long-term care residential and substance abuse settings for people with HIV AIDS health concerns in Los Angeles County. The rates were developed and implemented by solicitation for Residential and Substance abuse services for HIV and Aids in Los Angeles County in the winter of 2004, and were completed for Outpatient Clinical Services (Ambulatory Outpatient, Nutrition Counseling, Drug Adherence, Medical Specialty and Medical Case Management) in June 2005 with implementation pending. Plans are in place to adapt the rates to Mental Health Services for this population in 2005.

In December of 2003, work began on the development of the rate system for implementation with Developmental Disabilities services in the State of Montana.

Rationale for using the Arizona Model in Idaho

The ultimate financial challenge of any publicly funded health or social services program is that of satisfying widely divergent and ever changing needs with resources that are rigidly controlled and limited, in an environment of competing and sometimes opposing interests. To address these problems, many states have moved or are moving to standardized rate development.

The advantages that standardized rate systems offer (as opposed to lump sum or negotiated rates) follow the issues that pertain to any compensation strategy, and they are:

FAIRNESS AND EQUITY: The system should compensate at the same level for the same specific service, regardless of the provider agency. This means that when two agencies are providing the same service in the same way, with the same financial pressures (demographic considerations, etc.), they should be paid the same amount. Equity of standardized rates also provides for portability of services. No individual will be locked into services from one provider because the rate being paid to that provider is lower than what would be paid to other providers offering the same service. Consequently, people can transfer between providers seeking out the best and most attractive delivery of service without being restrained by budget impact issues.

RESPONSIVENESS TO INDIVIDUAL NEED: The system should be flexible and allow for changes in service authorization to follow individual needs without the need for a change in contract or rate. The rate should be directly tied to the level of need of the client, and vary with that need, but each and every provider providing the same level of support should receive exactly the same rate.

PUBLIC TRUST: It should introduce a very high level of accountability both in the provider community and in the program (funding) agency.

PROVIDER SUPPORT: It should be designed to be responsive to local economic conditions, as it establishes the variable costs according to the fiscal experiences in the local service environment and more closely compensates providers for their costs as it permits adjustments as these costs change through time.

In addition to these issues, which standardized rate mechanisms do adequately address, there are other issues that the process of standardization alone will not address, which must be considered separately.

For the very same reason that lump sum contracts and negotiated rates develop discretely and evolve into different levels of compensation for the same or similar service, reform of these compensation strategies involves changes that often represent increases to some providers but not to others. Rate reform is rarely budget - neutral if it is true, comprehensive reform. Consequently, rate reform requires revenue maximization initiatives to accomplish the parity that rate (or compensation structure) reform is intended to accomplish. There are several strategies that can be brought to bear for Medicaid revenue maximization (service funding transfer, waiver amendments to include previously unfunded services, administrative federal financial participation, etc.), which should be included in any financial compensation strategy project.

In the face of these issues, many resort to the conclusion that the solution is in more funding. However, this ignores all the complexity of these programs, and simplifies the issues where such simplification is not possible. The solution, as in so many areas of public services, is in consensus concerning the facts of the environment (limited funding, extensive legislative and political controls) and regarding a strategy that accomplishes the greatest good for the largest number of people in a less than perfect world.

The Arizona Model, which is a Staff Support Hour (SSH) rate approach, involves developing a single rate for a unit of staff time spent providing services for an individual needing them. This rate is expressed as a unit of time spent in the service/support rendered to the individual, rather than as time spent by the individual in a "program" (e.g., as attendance or census data). While the billable unit may remain a daily figure for the sake of simplicity, each daily rate will vary in exact relationship to the level of staffing the particular individual needs in order to be properly supported, as established by the process preferred by the funding agency (based on assessment results, interdisciplinary team consensus, application of eligibility criteria, etc.). In setting the daily rate for each individual, the staffing support needs of the individual affects the selection of the rate (that is, the maximum hourly staffing units allowed), but does not affect the billable unit. This approach enables a published rate environment to be created that fosters standardization of funding, while maintaining options for an "array of supports" that vary according to the needs of the of the individual.

This rate architecture represents an innovation that makes it truly possible for the "money to follow the person," while still having variability in service levels. In service systems in which this approach to rate setting has been introduced, it has been perceived as "fair" and "equitable," as services are provided according to individual needs, and not external factors. In view of the advantages this approach offers, the Idaho Department of Health and Welfare decided to implement the Arizona model to fund the state's Medicaid services.

Cost Components

Four standard cost components are assumed to be common to all social and medical services. These include:

1. Direct Service Staff Wage,
2. Employment-Related Expenditures,
3. Program-Related Expenditures (<u>not</u> direct expenditures), and
4. General and Administrative Expenditures.

Direct Service Staff Wage

The definition of the "Direct Service Staff Wage" consists of the following two elements:

- The staff must be people who are performing tasks in the furtherance of the objectives of the service. In other words, they must be doing what they are doing in order to meet some objective defined in the service. They are not considered Direct Service Staff solely by their qualifications.

- The person who is receiving the service and who is expected to benefit from it must be present most of the time. "Most" is defined as 90 percent or more.

There is a need to be specific in the definition of Direct Service Staff because service descriptions often describe minimal amounts of time that should be spent in any given period. In some cases, this may be provided by a variety of qualifying staff. Equally, there may be staff that have the same qualifications as customary Direct Service Staff present that are not performing tasks related to the service and so would not satisfy the minimum requirements of the service standard.

The hourly wage is determined by compensation studies that predict retention levels and the percentages for the other costs of service provision are determined by cost studies of actual service providers in order to describe the average range of expenses across the service environment for a group of providers.

Employment-Related Expenditures

Simply stated, these are all the benefits received by employees of the service agency. Benefits generally fall into two categories:

- **Discretionary Benefits:** those benefits that employers may elect to provide, but which are not mandated by any governmental authority, and
- **Non-Discretionary Benefits:** Those benefits that are mandated by a governmental authority.

Program-Related Expenditures

These are all the expenditures that support the objectives and the provision of the service, but cannot be tied to any particular person receiving the service. For this reason, Program-Related Expenditures are considered "indirect" rather than General and Administrative Expenditures. Supervision of Direct Service Staff, supplies related to the service, consultative services to general staff, transportation, and facility costs are all examples of Program-Related Expenditures. It is important to note that many factors influence the inclusion or exclusion of cost types in this category, but the two most prominent are the service descriptions and the funding source regulations.

General and Administrative Expenditures

These expenditures are the costs of being in business. General and Administrative Expenditures have nothing to do with the program, the service, or the product offered. These expenditures tend to be costs that are as common to automotive manufacturing firms as they are to pizza parlors or as common to doctor's practices as they are to amusement parks. General and Administrative expenses include administrative salaries, insurance, travel and entertainment, office expenses, program development/program director, lease or rental costs for office space, depreciation and amortization, interest on capital debt, real estate taxes, property insurance and other interests, miscellaneous, and equipment rental. In most instances, the categories of costs included in this component are similar in both non-profit and for-profit organizations.

Steps Followed in Idaho for Rate Development

On the following page, there is a flow chart describing the steps that were used in developing rates for Medicaid services in Idaho, using the Arizona model. The following narrative explains each step of the rate development with a description of the processes and actions taken to complete each of these steps successfully.

Step 1: Determined the Cost Categories

The first step in developing standardized rates for services was to study each service description in great detail to determine if the four cost categories described above would be sufficient, or if additional categories would be needed to address program and provider-specific issues. Where it was determined that additional categories were needed for a particular service, we have noted this in ***Chapter 4: Services in the Study.***

For example, federal regulations for the Medicaid Waiver Programs prohibit the inclusion of room and board expenditures in the daily rates set for community-based residential care facility services, but their inclusion is mandated in institutional settings.

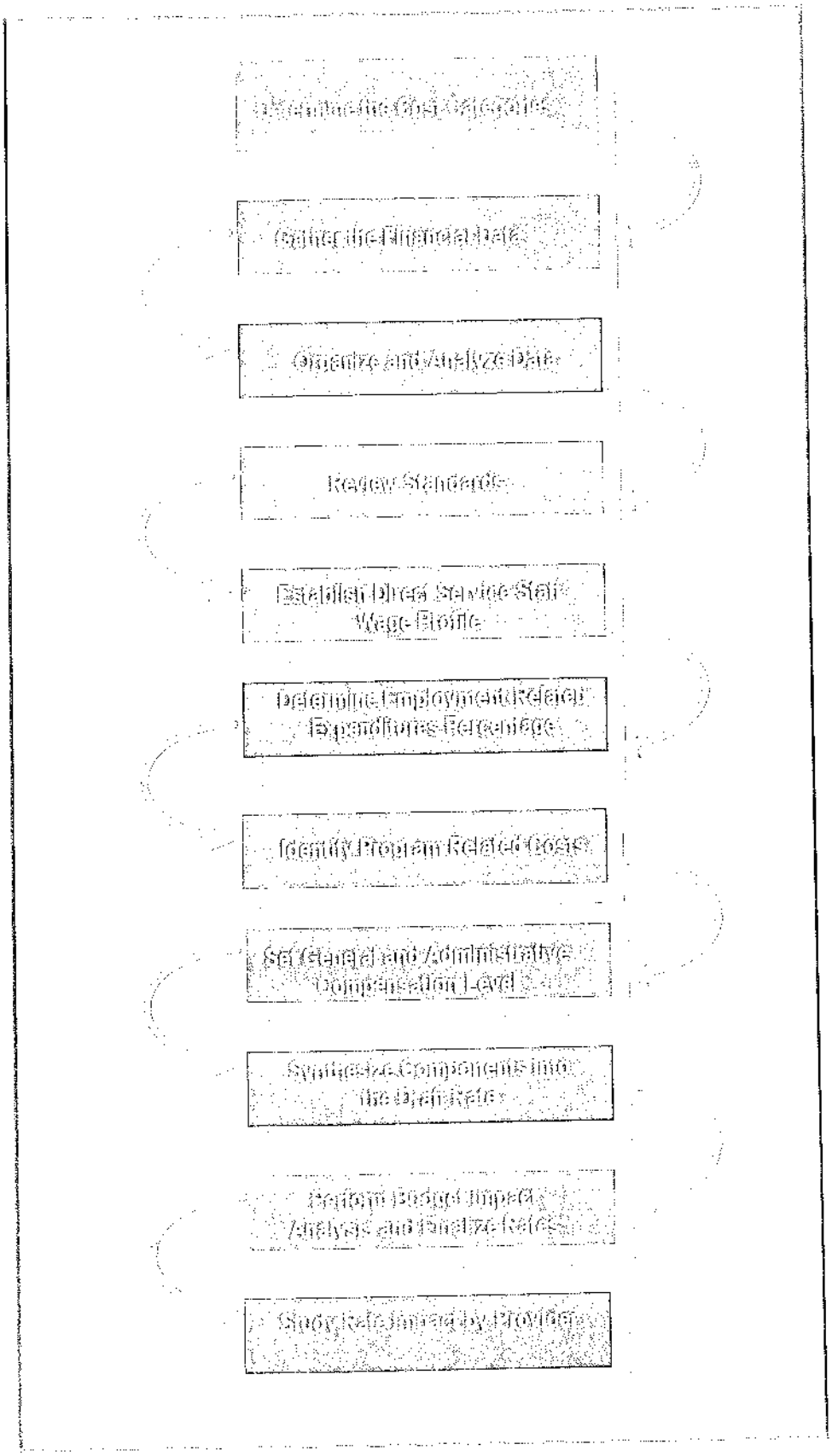
Some components will vary because of differences in the way services are described. For example, in some institutional and clinical settings, nursing and other medical care is considered an integral part of the services that each resident will need and levels of nursing are expressed as requirements of the service description. In the cases where this applied in Idaho, the medical personnel were considered as Direct Service Staff because the two parts of the definition of Direct Service Staff (furtherance of objectives and 90 percent client contact) have been met. In other settings, where medical services may or may not be occurring, or where it was occurring, it was more of a consultative nature to the facility itself and not specific to any particular client, the cost of the personnel was made a part of Program-Related Expenditures.

Step 2: Gathered the Financial Data

The next step we undertook was to determine the nature, quantity, and quality of existing expenditure data for providers, as documented in their cost reports and the audited financial statements. The underlying questions that were addressed as part of this exercise were as follows (in this order):

- Are there any line item cost reports related to the services?
- If so, are they in enough detail to be identifiable in the categorizations determined necessary in Step 1?
- If not, in what manner will the information be gathered?
- Assuming existing cost reports, are they current?
- Are existing cost reports reliable (i.e., do they correlate to any audited financial documents)?
- Assuming existing cost reports, are the line items contained within them somewhat consistent between providers of the same service?

Figure 1: Rate Development Methodology - – A Process Chart



These questions were intended to establish the requirement that provider cost information reports must meet the following conditions to be useable in rate development:

- They must be available (reports must exist).
- They should be current.
- They should be accurate and objectively supportable.
- They should be in enough detail to allow for categorization, according to the determined categories necessary.
- Line items within them should be consistent between providers of the same service.

Provider cost reports are very important to the process and form the basis of interpreting cost line items in the cost component categories of the structure.

In this project, the JVGA team requested spreadsheet files exported from the providers' general ledgers exactly as they were. Some questions arose as to how things were being categorized between agencies. Additionally almost all of the provider agencies lumped all wages into a line item referred to as "Wages" without further description that differentiate direct care staff wages from other wages.

Therefore, an intermediate step was required, wherein JVGA established a prevailing relationship between Direct Care Staff wages, and all others. To arrive at this relationship, JVGA requested the information from the provider community and applied the percentage breakouts to those general ledger reports where they were aggregated in "Wages" as a single line. In those cases where they were split out, the provider-reported splits were used.

Step 3: Organized and Analyzed Data

In this step, cost report information was organized so that the cost components could be compared in a consistent manner across providers. This organization of the information allowed for the successful completion of the component analysis. The final result of the component analysis was a true understanding of each of the cost components' relationship to Direct Service Staff costs for each of the service categories analyzed. Additionally, these components were expressed in terms of that relationship, as a percentage.

Step 4: Reviewed Standards

In the fourth step of development, existing service descriptions (or those prepared in earlier studies) were reviewed to establish the proper type and quantity of Direct Service Staffing levels and the general profiles of the Direct Service Staff specific to the service description. This information formed the basis of the completed rates.

In Idaho, this presented an additional complexity, because the configuration of staff is often blended between staff of significantly differing qualification levels. JVGA made every effort to capture the differences as reported by the providers, and observed by JVGA in site visits.

Step 5: Established Direct Service Staff Wage Profile

Wage levels associated with the staff described in the service descriptions as Direct Service Staff were then determined for each service. We researched the Bureau of Labor Statistics data to identify prevailing market wages currently paid by providers in the area. We discussed our findings with the administrative contact at the Department of Health and Welfare, in making a final decision on the wage levels to use.

The "Burger King Effect": This phrase has been used by JVGA staff to describe the difficulties provider agencies have in retaining appropriate staff. It may appear intuitive that unskilled labor at one business should be paid a similar wage as those others in another business. Nevertheless, this is not so in cases of private providers of services to people with developmental disabilities. While the qualifications of an individual working at a fast food restaurant may be identical to those in a community-based program for people with developmental disabilities, the conditions in which the jobs are done are very different. In other words, if the wages paid for direct staff are not reflective of the special dedication the job requires, the staff will opt for simpler jobs that pay the same. For this reason, JVGA does not use an unskilled labor category to determine wages for Direct Service Staff.

> *"People with developmental disabilities present very different needs than do individuals buying hamburgers. They are a wonderful but vulnerable segment of our population and it takes a special level of dedication to provide the kinds of supports they need."*

Step 6: Determined Employment-Related Expenditures Percentage

The Employment-Related Expenditure percentage was determined for each service. We did this by comparing the percentage revealed by the analysis of the cost reports to known information about benefit percentages. As with the wage levels, a decision was made as to whether to use the existing market percentage in the current providers' cost reports, or whether to use an objectively determined 'fully loaded' benefits package as might be available from an objective source, or to set this percentage by administrative discretion as a matter of policy.

Step 7: Set General and Administrative Compensation Level

General and Administrative Expenditures are almost always and almost completely 'fixed' in nature, which means that they do not vary in periods of less than one year. General and Administrative Expenditures are not related to the type of business (service or product) that an organization provides. However, this kind of cost component is extremely sensitive to scale. This implies that if a provider does a lot of business, the percentage will be lower and if a provider does very little business, the percentage will be higher. But, if the cost is expressed as a percentage, that percentage will be very different at every level of business activity. It also means that two organizations with exactly the same dollar amount of General and Administrative Expenditures, but with very different general levels of business will have very different General and Administrative percentages.

This creates a dilemma for rate setting because if it is not standardized, and cannot be expressed as a single percentage, it results in a very complicated rate system. Most government-funding agencies set General and Administrative reimbursement levels by policy and express the compensation limit as a single percentage. The General and Administrative percentage is also the factor that can be adjusted to create and compensate at separate levels of rates based on provider agency size or scale.

To properly calculate the General and Administrative percentage, first the Direct Service Staff wage plus the Employment-Related Expenditure plus the Program-Related Expenditure is subtotaled ("Subtotal 1" in the formula, below). This figure is then adjusted for the General and Administrative by "grossing up" the total by the General and Administrative percentage such that:

"Subtotal 1" divided by (1 – General and Administrative Percentage) = Total Rate.

When producing rate differentials to correctly fix the General and Administrative costs to a certain size of an agency, it is the General and Administrative percentage that is changed to accomplish the differential. However, it is important to note that this introduces variability in overall General and Administrative Expenditures for the system. As the mix of activity between agencies of different sizes changes, the overall General and Administrative percentage will change based on the different percentages paid to provider agencies of different sizes.

Step 8: Synthesized Components into Draft Rate and Made Additional Adjustments

In this step, all the numbers obtained through the previous steps were combined and reassembled, using the base wage for the Direct Service Staff and the appropriate percentages for the other cost components.

The JVGA team, in response to an existing service need, made an additional adjustment, to create an acuity-based differentiated rate. The assumptions made with regard to the authorization of the applicability of the rate relate to the intensity of need presented by the individual receiving the service. Typically, those individuals who exhibit behaviors that are classified as dangerous to themselves or others would be appropriate for an acuity-based rate. This group includes people with elopement behaviors, predatory behaviors, and people with Prader-Willi Syndrome who are not able to regulate their eating behavior.

Step 9: To Perform Budget Impact Analysis and Finalize Rates

After the rates for the specific categories of service are prepared in draft and reviewed, we will proceed to a budget impact analysis to study the effect of the rates on the existing service budget.

Step 10: To Study Rate Impact by Provider

In many environments, multiple rates exist for the same service, because of a history of negotiations. If these varying rates were to be replaced with a standardized published rate system for the very same services and for the very same providers and recipients, some providers will see increases and some may see decreases in reimbursement rates. For this reason, the impact of

the rate system on each provider to determine the amount of increase or decrease they will experience must be determined.

The rate setting methodology recognizes that beyond a certain level, a decrease could be devastating to a provider and would jeopardize their financial health. Consequently, the loss profile of the individual providers is studied to determine if any are at intolerable risk of loss. For providers whose potential loss exceeds what would be considered tolerable, the loss can be "stopped" at some level considered acceptable. Correspondingly, any increases that exceed the same level can also be "stopped" to keep the entire system in balance in a process referred to as "banding the loss." Additionally, the rate structure assumes that increasing other sources of revenue can mitigate the negative impact that the rates may have on some of the providers and the effort to maximize funding from these alternate sources is strongly encouraged.

Adjustment Factors

Adjustment factors are those elements that might change in the rate system after it has been introduced. It is important to note that in any rate system, changes that occur in the financial environment that directly relate to the components of the rate system do not automatically initiate a change in the established rates.

- The most common adjustment factor is an adjustment based on size of the provider organization, as noted previously. The provider interviews and evaluations of cost reports usually indicate that there is considerable variation in size among the various providers. Based upon the review, the rate component that is most likely to vary with scale is the percentage of General and Administrative expenses. This is because this category accounts for the majority of the fixed costs for any provider and is most responsive to scale/size considerations. Adjustments to the proposed rate may be used to ensure that smaller providers are not placed at an undue competitive disadvantage. Thus, adjustments are made to reflect the differences in General and Administration expenses between providers of various sizes.

- Wage levels change every year and may become out-of-date. "Unfunded mandates" are usually not at the discretion of either the providers or the funding agency (unemployment insurance rates, workers' compensation, etc.).

- Changes in service descriptions can also have a profound influence on the continued accuracy of the published rates – so, as these change, it will be necessary to take another look at whether the rates would be affected.

Adjusting rates for issues noted above, and the timing of rate changes, are policy decisions that would need to be made by the Department of Health and Welfare.

Implementation Considerations

1) The final authorization of the rate (and staffing levels) rests with the Department of Health and Welfare, as they remain responsible for authorizing contracts or individual services and therefore must remain in control of the implementation process.

2) The budget impact of service delivery needs to be reevaluated over time as authorization levels change - establishing a financial measuring capacity will be necessary.

3) Every provider agency providing the same service will need to receive the same rate -- if rate negotiations are permitted, the perceived fairness and equitability of the Staff Support Hour approach would be compromised.

4) Financial and Service Level Reviews of the provider's service delivery will need to be performed, as additional quality assurance, to verify that agreed-upon services have been delivered.

Future Rate Change Process

Pressure to revise the rate amounts can and will occur without the necessity to change the architecture of the rate system itself. The system is adaptable to change by appropriate adjustments to the calculations within the system. Some areas where changes could occur are as follows:

- If political will exists to increase the assumption of Direct Service Staff Wage levels and the decision to increase them is made and funded, the wage levels can be immediately changed and the rates will automatically recalculate.
- If unfunded mandates become funded, those changes can be made to the appropriate component (usually Employment-Related or General and Administrative Expenditures) and again, the rates will automatically recalculate.
- Service descriptions will usually affect either the Direct Service Staff profile or the Program-Related Expenditure percentage. If so, these may involve a more complicated recalculation of the rate system components but the architecture remains unchanged.

ATTACHMENT 5

Editorial: Opioid addiction is a clear, present danger

SR spokesman.com/stories/2017/aug/[illegible]

After a brief period of balking, the Trump administration on Thursday agreed with its own commission that the nation's growing opioid crisis constitutes a national emergency. The delay made little sense, because the statistics are just stunning, according to a variety of federal sources.

More than 52,000 Americans died of drug overdoses in 2015, according to the Centers for Disease Control and Prevention, with 33,000 deaths coming from opioid overdoses. It's the leading cause of accidental death, surpassing car crashes. The President's Commission on Combating Drug Addiction and the Opioid Crisis issued a report on Monday that said the death toll was tantamount to a "September 11th every three weeks."

In 2015, heroin deaths outpaced gun-related homicides for the first time.

More Americans used prescription painkillers in 2015 than all forms of tobacco combined, according to a recent Substance Abuse and Mental Health Services Administration report. That doesn't mean the drugs are always misused, but it does indicate their prevalence.

The rise in overdose fatalities followed the aggressive marketing and increased prescribing of painkillers in the early 2000s, according to a Washington Post article. State and federal authorities then cracked down on "pill mills" and tightened prescribing guidelines. As a result, many addicts switched to heroin, which is cheaper. Legal and illegal opioids are intertwined, because those addicted to prescription painkillers are far more likely to become hooked on heroin.

While fatalities related to prescription drugs have dropped, those related to heroin have risen. And if that weren't enough, powerful synthetic opiates such as fentanyl have emerged. Fentanyl can be bought surreptitiously on the "dark web" and shipped via mail, making purchases extremely difficult to detect.

No state has been immune to the crisis. Opioid-related addictions and fatalities have risen dramatically in Washington and Idaho.

In a rare show of bipartisanship late last year, Congress passed the 21st Century Cures Act. The law expands opioid treatment programs.

However, many addicts access treatment with Medicaid coverage, so any plans politicians have to cut Medicaid will also undermine care. Idaho could expand access to treatment by agreeing to expand Medicaid. Many of the patients with Spokane's largest opioid treatment program, run though the Spokane Regional Health District, gained coverage via Medicaid expansion.

Under a national state of emergency, a rule restricting where Medicaid recipients can get treatment could be lifted. Access to medications that help treat addiction could be expanded. Barriers to Medication-Assisted Treatment, which has proven to be successful, should fall.

But just as important, a huge spotlight will be trained on a drug crisis that's worse than the crack cocaine epidemic of the 1980s. It's important that the nation react more smartly now it did back then, when the crisis was met with draconian laws and stiff sentences, and treatment was given short shrift.

Clearly that didn't work, so we must resist the lure of the easy fix.

The Spokesman-Review Editorial Board

Members of The Spokesman-Review editorial board help to determine The Spokesman-Review's position on issues of interest to the

ATTACHMENT 6

Catherine Libby
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Professional Profile

High-performing operations manager skilled at solving complex problems and delivering solutions focused on strategic alignment, process improvement, quality outcomes, and effective use of resources.

Proven ability to build and sustain cooperative relationships with internal and external customers.

Innovative, responsive leader focused on maximizing individual and team strengths.

Excellent knowledge of health care and human service delivery systems. Over 24 years of expertise in interpreting and applying complex governing laws, regulations, policies and procedures.

Considerable experience monitoring and demonstrating program compliance and managing external audit activities.

Considerable experience in business process analysis, program development, procurement processes, contract management, human resource management and project management.

Major Accomplishments

Provided leadership and management for state-wide Medicaid bureau operations encompassing medical care, utilization management, pharmacy services, home and community based services, developmental disability services, long-term care, contract management, Medicaid financial operations, data analysis, Medicaid Information systems, appeals, compliance and audit activities.

Successfully led Idaho's Medicaid Management Information System (MMIS) operations from post-implementation turbulence to sustained stability through strategic contract administration, development of excellent vendor relationships, and implementation of corrective action initiatives to ensure the terms of the MMIS contracts were met or exceeded.

Led planning, execution, and successful completion of federal certification review for the four major automated systems and associated fiscal agent services that comprise Idaho's Medicaid Management Information System (MMIS), resulting in approval of enhanced federal funding for MMIS operations.

Successfully managed numerous multi-million-dollar projects focused on federal compliance, process improvements and implementation of statewide healthcare initiatives, including: Department's implementation of Health Insurance Portability and Accountability Act (HIPAA) standards; implementation of the Medicaid for Workers with Disabilities program; Idaho's 2006 Medicaid Reform Initiative; implementation of the National Healthcare Provider Identifier standard; and implementation of the Medicaid Correct Coding Initiative.

Led operational compliance efforts resulting in resolution of all outstanding Legislative audit findings for the Idaho Medicaid program, with no new audit findings for the two most recent SFYs.

Professional Experience

2015-2017 – **Deputy Administrator of Medicaid Operations**, Division of Medicaid
State of Idaho, Department of Health and Welfare

Provided statewide leadership and direction for Medicaid program operations. Managed quality, integrity, and compliance activities to ensure sustainable and integrated service delivery systems with emphasis on business process improvement. Developed and evaluated program partnerships, cooperative relationships, models, and practices in support of strategic objectives. Provided direct leadership to four Bureau Chiefs and MMIS Support teams. Responsible for maximizing use of program resources to support program quality and innovation.

2013-2015 – **Project Manager 3** – Information Technology Services Division
State of Idaho, Department of Health and Welfare

Responsible for all aspects of project management for complex, enterprise-level technology projects, including research, analysis, planning, scope development, prioritization, change management, budget control, work plans, timelines, risk analysis, quality assurance, status reporting, operational readiness, implementation strategies, contingency planning and post-implementation project close out. Provided leadership for project team members and directly managed enterprise project support staff.

2011-2013 - **Project Manager 3** – Division of Medicaid
State of Idaho, Department of Health and Welfare

Responsible for daily system operations and compliance with federal certification requirements for the integrated systems that make up Idaho's Medicaid Management Information System (MMIS). Managed operations and project teams. Provided leadership and management for multiple, concurrent system enhancement projects. Responsible for integration and data exchange between the MMIS and numerous state and federal interfacing systems. Primary point of contact for supplier relationship management and multi-vendor system integration. Responsible for managing multi-million dollar operating budgets, tracking and approving costs associated with system enhancements, negotiation of contracts and contract amendments. Oversaw compliance and quality assurance activities. Developed and managed multiple formal requests for enhanced federal funding.

2008-2011 – **Project Manager 2** – Division of Medicaid
State of Idaho, Department of Health and Welfare

Worked under the direction of a Senior Project Manager to modernize Idaho's MMIS technology and fiscal agent services. Worked with multiple vendors and contracts to implement solutions to meet state and federal Medicaid requirements. Assisted with project planning, execution, testing and evaluation activities. Participated in development of project goals, work plans, timelines, implementation strategies, and evaluation methods. Managed project staff and monitored contracts. Assisted with communication activities, provided status reports to project sponsors and managed federal reporting.

2007-2008– **Automated System Manager** – Division of Medicaid
State of Idaho, Department of Health and Welfare

Responsible for ensuring Idaho's MMIS operated in compliance with federal and state regulations and federal system certification requirements. Managed vendor relationships, monitored contract performance. Negotiated contract amendments and cost estimates for Medicaid system enhancements. Managed system support team members.

2006-2007– **Project Manager 2** – Division of Medicaid
State of Idaho, Department of Health and Welfare

Responsible for all aspects of major Medicaid projects including planning, monitoring scope, schedules, budgets, preparing funding requests, analysis, interpretation of federal and state laws and regulations, leading workgroups, reviewing and approving technical and operational project deliverables, coordinating readiness activities, overseeing testing, coordinating implementation and post-implementation activities. Identified and reported project risks and recommended mitigation strategies, led contingency planning, post-implementation evaluation, quality assurance monitoring and oversight of corrective action plans.

2005-2006– **Program Research and Development Analyst** – Division of Medicaid
State of Idaho, Department of Health and Welfare

Responsible for grant administration, project management, research and analysis, program development. Developed and managed contracts, authored reports and managed budgets. Assessed business impacts, designed and revised business processes. Managed stakeholder coordination, communication and collaboration. Created quality assurance plans and managed compliance monitoring activities.

2002-2005 – **Training Specialist**, Information Technology Services Division and Division of Medicaid
State of Idaho, Department of Health and Welfare

Acted as Operational Implementation Lead with responsibility for facilitating transition of Medicaid program operations to full compliance with HIPAA standards. Responsible for project management, business process mapping, impact assessment, work plans, schedules and status reporting. Developed stakeholder communication and transition plans. Managed internal and external workgroups. Reviewed and approved project deliverables, planned and coordinated operational implementation strategies. Identified and reported risks and recommended mitigation strategies. Monitored project scope and progress. Managed contingency planning and post-implementation corrective actions.

2001-2002 – **Acting Program Manager**, Division of Welfare
State of Idaho, Department of Health and Welfare

Supervised Medicaid Eligibility, Aid for the Aged, Blind, and Disabled (AABD), Food Stamps, and TANF Program Specialists. Responsible for program policy development and technical assistance for benefit program operations. Oversaw compliance with diverse federal and state regulations, eligibility criteria, and related business processes. Responsible for managing relationships with federal partners, community stakeholders, and providing prompt and accurate technical assistance to field office staff.

2000-2001– **Welfare Training Specialist**, Division of Welfare
State of Idaho, Department of Health and Welfare

Acted as Business Analyst and Subject Matter Expert for the Division of Welfare's "Simplify Notices" and "Automate Medicaid Eligibility Determination" (AMED) projects. Assisted Senior Project Manager with project initiation, including identification of stakeholders, project goals and objectives, scope identification and risk analysis. Coordinated and facilitated project initiation and Joint Application Design sessions. Gathered and documented detailed business requirements. Analyzed and documented operational impacts, process changes and operational resource needs.

1999-2000– **Self-Reliance Program Specialist,** Division of Welfare
State of Idaho, Department of Health and Welfare

Responsible for analysis, interpretation, and compliance with federal Medicaid, Social Security Act, related Code of Federal Regulations, related state legislation, related promulgated rules and State Plans for Idaho's Medicaid program. Acted as a subject matter expert on multiple Medicaid eligibility program development initiatives. Responsible for responding to statewide requests for technical assistance, preparing rule dockets and drafting program rules. Responded to inquiries from program participants and members of the community. Conducted policy research and quality assurance activities. Maintained eligibility-related portions of state plans. Created and maintained program reference materials. Provided technical consultation to internal and external partners.

1998-1999 – **Welfare Training Specialist**, Division of Welfare
State of Idaho, Department of Health and Welfare

Planned, conducted and evaluated individual and group training for regional benefit program staff, covering program purpose, laws, regulations, policies, procedures, automated system operation, caseload management, resource materials, interviewing techniques, and related topics. Assessed technical training needs. Developed, maintained, and implemented regional training plans. Participated in the development of state-wide division training plans, curriculums, and modules. Developed, updated, and adapted technical training materials to address training needs. Evaluated effectiveness of welfare training programs.

1993-1998– **Welfare Eligibility Examiner and Self-Reliance Specialist**, Division of Welfare
State of Idaho, Department of Health and Welfare

Responsible for determining eligibility for Medicaid, food stamp, cash assistance and child care assistance programs. Interviewed applicants and program participants. Evaluated participant needs and made referrals for community/agency resources. Responsible for applying knowledge of policies in collecting, verifying, interpreting, and acting on personal information gathered from various sources to support initial and on-going qualification criteria for benefits programs. Performed complicated analytical problem resolution. Responsible for accurate and timely data entry.

Education

Bachelor of Science- Business Management, information technology focus - Western Governors University

ATTACHMENT 7

JULIE ANN HAMMON
3955 Dundee Drive
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MAJOR ACCOMPLISHMENTS

Lead the Transition of the Family Medical Unit, Statewide
New Service Delivery Implementation, Region 3
Lead the development of EVERIF-I (electronic verification system)
IBES Implementation, Statewide
Policy and Process Implementation of the Affordable Care Act, Statewide
Policy and Process Implementation of Advanced Premium Tax Credit, Statewide
Creation and Implementation of the Your Health Idaho Call Center
Transition of the Your Health Idaho Call Center to YHI
Idaho Child Care/IBES Implementation, Statewide

EXPERIENCE

Deputy Administrator, Division of Welfare
State of Idaho
Department of Health and Welfare
Immediate Supervisor: Lori Wolff, Boise 334-6599
April 2014-Present

Direct Program and Policy Design for all state-driven programs in the Division of Welfare including Food Assistance (SNAP), Medicaid eligibility (with about 30 variants), Cash Assistance, Insurance Premium Tax Credit (APTC) eligibility for Idaho's Insurance Marketplace, Child Care, and Child Support. Administration of all state-driven statewide service delivery by state staff (approximately 500 staff). Operational Design and Coordination for all state-driven services, including process engineering and personnel management. Ensure statewide processes are well designed, documented, and followed. Create and coordinate communication and cultural orientation strategies and implementation within SR Programs, other DHW organizations, and necessary federal entities. Coordinate policy, authorization, audit, operations, and funding between Federal program funders/administrators and SR Programs. Direct Division strategic prioritization, planning, implementation and evaluation. Monitor progress to strategic (long term) and tactical (short term) business objectives, within the categories of customer service, staff morale, program funding, and program compliance. Direct and manage program (Trustee and Benefits), personnel, and operating budgets. Evaluate options and when necessary create and present statutes and rules to Legislators that support state and federal regulations, state budgets, and operational practices.

Self-Reliance Operations Bureau Chief
State of Idaho
Department of Health and Welfare
Immediate Supervisor: Lori Wolff, Boise 334-6599
April 2010-April 2014

Design, develop, and manage the operations of a statewide benefit delivery system. Responsible for the daily operations of the service delivery field offices and processing centers, the statewide process development unit, the statewide training unit, and providing automation requirements. Direct the development, implementation, staffing and evaluation of statewide delivery system. Ensure policy, process and automation align to support statewide staff in serving the families in Idaho eligible for Welfare services. Provide program consultation and coordination with other department units as well as with other agencies and provider client groups to ensure program effectiveness. Responsible to ensure operations comply with state and federal rules and regulations and align those to the actual practice. Request and approve funding for operations. Work with local, state, and federal partners in explaining operations, reviewing practices, and alignment to policy.

Statewide Business Design Program Manager
State of Idaho
Department of Health and Welfare
Immediate Supervisor: Lori Wolff, Boise 334-6599
August 2009-April 2010

Develop and design statewide processes that align with our service delivery model; provide requirements and priorities for our automated system; implement organizational change within a service delivery program; test and provide outcomes and results related to the automation system; apply measurement processes/methods for assessing program outcomes or progress toward goals; preparing and presenting oral presentations to groups; use experience and knowledge of laws, regulations, policies and procedures governing federal and state Food Stamps, Cash and Medicaid programs to provide requirements for the new automated system and develop processes for the field offices statewide; and develop and implement processes related to customer service, the automated system, and the service delivery for the statewide work force.

Program Manager- Operations
State of Idaho
Department of Health and Welfare
Immediate Supervisor: Lori Wolff, Boise 334-6599
December 2005-August 2009

Develop and implement priorities, procedures, and guidelines for all regional Self Reliance staff; develop strategies to achieve statewide and regional priorities; Responsible for development and direction for a regional operation as well as helping to set direction for a statewide system; provide leadership to ensure a sustainable and integrated services system; direct supervisors and staff around priorities and processes; identify, develop, implement and evaluate program partnerships, cooperative relationships, models and practices that position the program to support Department strategic objectives through the work with other regional programs.

Self-Reliance Supervisor
State of Idaho
Department of Health and Welfare
Immediate Supervisor: Rosie Andueza, Boise 850-2197
August 2003-Dec 2005

Develop and implement priorities, procedures, and guidelines within the Caldwell office; hire, train and evaluate staff; negotiate with staff to set realistic goals and develop strategies to achieve those goals; coach and mentor staff in meeting the Department standards; use the principles and skills of the Learning Organization to create, acquire and share knowledge; help staff modify behavior to reflect new knowledge and insights; assign and adjust caseloads to meet Department deadlines and client needs; review case documentation and actions; advise and assist staff on problem cases, work methods, control systems, and interpretation and application of policies and procedures; assess staff training needs and prepare, present or coordinate training; analyze, interpret, and provide input regarding regional and state program policies and procedures; review cases; review administrative hearing requests and conduct pre-hearing conferences.

Self-Reliance Specialist
State of Idaho
Department of Health and Welfare
Immediate Supervisor: Virgil Smith, Payette
June 1991-August 2003

Personal interaction with participants and related agencies when family and individual circumstances were being addressed; negotiation; problem resolution; outcome-based contract development; coaching, confrontation, and personal needs assessment with participants; coordinate participant services; evaluate work skills; explore employment opportunities; negotiate with participants setting realistic goals and strategies to achieve self reliance; refer clients for resources such as counseling, mental health, substance abuse evaluations, and child protection; investigate alleged program abuse; gather, verify, interpret, and act on personal information gathered from various sources to support initial and on-going qualification criteria for the benefits and services of the program. Completed daily record reviews for case documentation and actions; advise and assist staff on problem cases, work methods, control systems, and interpretation and application of policies and procedures for benefit programs; evaluate and ensure program compliance with policies, rules and regulations.

EDUCATION

Certified Public Manager, CPM; 300-hour course in four study areas which include: General Administration & Organization, Technical & Quantitative, Analytical &Conceptual, and Human Skills. Additional education includes: Front Line Leadership, Communication Skills, Building Work Relationships, Individual Leadership Style and Effect, Situational Leadership, Managing Individual Performance, Identifying & Resolving Problems, Emotional Intelligence, and Negotiation and Mediation. Emerging Public Management Roles. Legislative Protocol, Effective Presentations, Effective Writing, Employment Law, Risk Management, Behavioral Interviewing, The Manager as Facilitator, MBTI & Communication, Research and Analysis, Administrative Law, Contract Management, and Information Management.

ATTACHMENT 8

JAMES P. PRICE
3587 Somerset Drive
Pocatello, Idaho 83201
(208) 240-4591
E-mail: James.Price@dhw.idaho.gov

Education

Syracuse University, Syracuse, New York

College of Law, Juris Doctorate, *cum laude*, December 1992

Maxwell School of Citizenship and Public Affairs
Master of Public Administration, December 1992

Brigham Young University, Provo, Utah

Bachelor of Science, Social Work, December 1986

Licenses

Licensed to practice law in Idaho and Utah (all state and federal courts)

Employment

July 2017-Present — **State of Idaho, Department of Health and Welfare, Division of Behavioral Health, State Hospital South**
Blackfoot, Idaho
Hospital Administrator, Behavioral Health Hub Administrative Director

March 2015-June 2017 — **State of Idaho, Department of Health and Welfare, Division of Behavioral Health, State Hospital South**
Blackfoot, Idaho
Assistant Hospital Administrator
Managed the hospital's operations departments, including business office, billing office, support services (maintenance, custodial, dietary, safety and security), materials management, performance improvement, data collection, and electronic medical record system. Oversaw the development and management of the hospital's budget and Medicare/Medicaid cost reports. Approved personnel actions. Actively consulted with the hospital administrator regarding patient and personnel issues.

March 2004-March 2015 — **State of Idaho, Office of the Attorney General, Contracts & Administrative Law Division,** Pocatello, Idaho
Deputy Attorney General
Represented the Idaho Department of Health and Welfare, Region VI, and State Hospital South in all stages of judicial and administrative proceedings in program areas such as child protection, child support, public assistance, adult and children's mental health, developmental disabilities and child care. Provided counsel to Department management and staff on legal issues related to these programs.

June 1999-March 2004 — **Cooper & Larsen, Chartered,** Pocatello, Idaho
Attorney
General practice of law with emphasis on civil and commercial litigation, real estate, employment rights and discrimination, construction, bankruptcy, probate, guardianship, conservatorship, adoption and estate planning.

Aug. 1994- May 1999	**Racine, Olson, Nye, Budge & Bailey, Chartered**, Pocatello, Idaho Attorney See description of practice for Cooper & Larsen above.
May 1993- July 1994	**Denver County Social Services**, Denver, Colorado Director of Intake, Adult Financial/Medical Services Established and managed intake unit, including hiring personnel and writing all policies, procedures and quality assurance measures, for processing applications for public assistance for adults without children. The unit processed more than 1,000 applications per month.
Sept. 1991- Dec. 1992	**Student Legal Services, Inc.**, Syracuse, New York Law Clerk
Mar. 1987- Aug. 1990	**State of Utah, Department of Social Services, Office of Family Support**, Logan, Utah Intake Worker
Dec. 1985- Mar. 1987	**State of Utah, Department of Social Services, Utah State Training School**, American Fork, Utah Social Service Worker Intern
Mar. 1985- Oct. 1985	**State of Utah, Department of Social Services, Utah State Training School**, American Fork, Utah Developmental Specialist

Presentations

Made several presentations concerning the Child Protective Act to foster parent groups, Court Appointed Special Advocates, and others. Conducted trainings on privacy and HIPAA issues with DHW agencies. While practicing law, held trainings on estate planning and other issues with investor and community groups.

ATTACHMENT 9

	A	F	I	O	V	AB	AC	AD	AE	AH	AI
1	Total										
2	FY17 Actuals										
3		PUBLIC			BEHAVIORAL		Healthcare	Licensing		INDEPENDENT	
4		HEALTH	WELFARE	FACS	HEALTH	MEDICAID	Policy	& Cert.	Indirect	COUNCILS	
5											
6											Total
7	FY17 JFAC Action Approp:										
28	TOTAL	115,757,100	168,949,700	103,048,600	98,320,000	2,233,804,900	10,235,900	7,513,900	40,723,200	9,001,300	2,787,359,200
29											
30	Adjustments:										
31	General Fund Supplemental / Rescission	128,600	118,300	868,100	127,700	(6,090,900)	-	-	(244,900)	-	(5,095,100)
32	Federal Fund Supplemental	941,700	-	-	1,627,700	(15,767,600)			1,360,000	-	(11,838,200)
33	Receipts Supplemental	-	-	-		10,000,000	-	-	-	-	10,000,000
34	Dedicated Fund Supplemental	-	-	-	-	-	-	-	-	-	-
35	Non-Cog Funds	-	-	-		-	-	-	-	-	-
36	Object Transfers	-	-	-	-	-	-	-	-	-	-
37	Transfers from FY16 Request (DU 6.5x)	-	879,800	(249,800)	-	-			(630,000)	-	-
38	Transfers - Receipt Authority	12,000	(175,000)	(20,300)	-	(760,000)	-	-	925,000	8,300	
39	Transfers - Federal Fund Authority	-	-	(250,000)	250,000	-	-	-	-		-
40	Transfers - General Fund	-	318,200	11,300	139,700	4,000	-	215,000	(687,900)	-	-
41	Transfers - H= Programs	-	-	-	-	-	-	-	-	-	-
42	Transfers - Public Health Programs	-			-	-	-	-	-	-	-
43	Transfers - FACS Programs	-	-	-	-	-	-	-	-	-	-
44	Transfers - Non-Booked Transfers	-	(115,700)	(248,900)	1,310,700	(461,000)	-	-	(485,100)		
45	Transfers - Non Booked Medicaid T&B	-	-	-	-	-	-		-	-	-
46	Receipts to Appropriation	30,400			4,700	-	-	-	96,700	-	130,800
47	Reverted Federal Fund Authority	(5,262,200)	(7,152,300)	(4,991,000)	(3,410,000)	(38,111,500)	(739,800)	(125,800)	(1,300,900)	(1,177,900)	(62,152,200)
48	Reverted Dedicated Fund Authority	(6,997,000)	(739,000)	-	(103,100)	(18,695,100)	-	-	-	(112,100)	(25,576,300)
49	Reverted Receipt Authority	(2,464,200)	-	(1,588,200)	(699,700)	(42,071,700)	-	(21,500)	(18,200)	(6,600)	(46,799,100)
50	General Fund Carryover	-	-	-	-	-	-	-	-	-	-
51											
52	Total FY17 Est. Approp. with adjustments	103,155,300	162,042,000	96,672,500	97,607,700	2,121,960,700	9,526,400	7,586,600	39,763,900	7,714,000	2,646,029,100
53											
54											
55	Expenditures	103,058,500	161,582,500	96,460,400	96,355,900	2,121,358,600	9,526,400	7,579,400	39,759,500	7,714,000	2,643,394,200
56	Variance from Appropriation	96,800	459,500	212,100	1,251,800	602,100	-	7,200	5,400	-	2,634,900
57											
58	General Fund Reversion	96,800	459,500	212,100	1,251,800	602,100	-	7,200	5,400	-	2,634,900
59											
100											
101	General Fund Over <Under> by Object										
102	Personnel	26,900	199,200	44,000	117,400	-	-	4,300	-	-	386,800
103	Operating	59,900	-	39,900	119,800	-	-	2,800	-	-	222,400
104	Capital	-	300	400	5,700	-	-	100	5,400	-	11,900
105	T&B	8,000	257,000	127,800	1,008,900	602,100	-	-	-	-	2,013,800
106	Total:	96,800	459,500	212,100	1,251,800	602,100	-	7,200	5,400	-	2,634,900
107											
109	Total of General Fund Appropriation:	$ 7,900,500	$ 40,914,300	$ 36,514,600	$ 56,044,900	$ 513,515,300	$ -	$ 1,804,700	$ 13,896,200	$ 122,000	$ 672,712,600
110											
111	Reversion Percentage:	1.2%	1.1%	0.6%	2.2%	0.1%	0.0%	0.4%	0.0%	0.0%	0.4%

ATTACHMENT 10

DEPARTMENT OF HEALTH & WELFARE

FY19 Proposed Decision Units (for SFY 2018 really)

SUPPLEMENTALS

DRAFT - FOR DISCUSSION PURPOSES ONLY

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Dept. Priority/DU #	Division	Program	Description	One Time	FTP	Funding General	Total
2	Behavioral Health	Children's Mental Health	Youth Empowerment Services (YES)	Y	-	$ 322,300	$ 644,600
5	Behavioral Health	SHN	Contracted tele-psychiatrist, contract nurse practitioner, proposed nurse comp plan.: Contracted Tele-psychiatrist – $50,000 Contracted Nurse Practitioner - $50,000 Proposed Nurse compensation increase plan - $61,800 ongoing (All positions are full-time and fully benefitted). The supplemental portion of the request is for $16,600 with an annualization of $45,200 for fiscal year 2019.	Both	-	$ 116,600	$ 116,600
5	Behavioral Health	Community Hospitalization	Community Hospitalization Shortfall	Y	-	TBD	TBD
5	Behavioral Health	SHS	SHS fund adjustment	Y	-	TBD	TBD
BEHAVIORAL HEALTH SUBTOTAL					-	$ 438,900	$ 761,200
3	FACS		Child Welfare Social Workers and Supervisors: Funding to support front line delivery of services to Child Welfare clients and related families and to modify processes to improve Child Welfare System. FTP authority from 13 vacant positions (10 S/R + 3 FACS)	N	-	$ 254,100	$ 508,200
FACS SUBTOTAL					-	$ 254,100	$ 508,200
1	Medicaid	Financial Operations	Trustee and Benefits Held Payments from SFY 2017: During the end of SFY 2017, Medicaid did not have enough general fund appropriation due to not collecting enough drug rebate receipts to cover a portion of the final trustee and benefit payments on June 26th.	Y	-	$ 10,616,400	$ 54,085,300
1	Medicaid	Financial Operations	Trustee and Benefits Shortfall: Additional T&B appropriation request to meet the Medicaid coverage need based on Medicaid's forecast.	Y	-	TBD	TBD
1	Medicaid	Financial Operations	Receipt authority for general receipts decrease: Receipts need to accommodate a decrease in receipt authority due to a decrease in hospital cost settlements.	N	-	TBD	TBD
2	Medicaid	BDDS	KW Lawsuit Compliance with Court Order: This request covers the cost of developing a new supports budget methodology as court ordered in the KW lawsuit settlement agreement. The Department has partnered with Human Services Research Institute (HSRI) to develop, test, and assist in implementation of the new methodology.	Y	-	$ 105,700	$ 213,500
2	Medicaid	BDDS	KW Lawsuit Compliance - Legal Fees: This request covers the cost to implement court-ordered training to support adequate due process for adult Medicaid participants with developmental disabilities who contest the department's decision at hearing.	Y	-	$ 49,000	$ 98,000
4	Medicaid	Financial Operations	Personal Assistance Services Rate Changes: The Department conducted a cost survey of Personal Assistance Agency and Assisted Living Facility providers in 2017 to establish reimbursement rates and address participant access to services in accordance with administrative rule section IDAPA 16.03.10.037. Providers have stated that they are experiencing high turn over in service delivery staff.	n	-	TBD	TBD

DEPARTMENT OF HEALTH & WELFARE
FY19 Proposed Decision Units (for SFY 2018 really)

SUPPLEMENTALS

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	B	E	F	I	J	K	L	P
7	Dept.				One		Funding	
8	Priority/DU #	Division	Program	Description	Time	FTP	General	Total
22	4	Medicaid	Financial Operations	**Supported Living Services Rate Changes:** The Department conducted a cost survey in order to establish reimbursement rates in accordance with administrative rule section IDAPA 16.03.10.037. The Department has worked extensively with providers and the Centers for Medicare and Medicaid (CMS) to finalize a reimbursement methodology that accurately reflects the cost to provide these services.	n	-	TBD	TBD
23	4	Medicaid	Financial Operations	**Children's Developmental Disability Agency Rate Changes:** 2017 cost survey. These providers service array include the following: individual and group habilitative support and intervention services, individual and group family education services, individual and group respite services, therapeutic consultation services, and crisis intervention services.	N	-	TBD	TBD
24	6	Medicaid	Medical Care	**Clinical Quality Measurement System Development:** 2nd year of a project ending 9/30/2020. This funding will assist Patient Centered Medical Homes (PCMH) to submit clinical quality measures to Idaho's Health Information Exchange (HIE) and furthers Idaho Medicaid's strategic objectives to transform the state's primary care landscape to a Patient Centered Medical Home (PCMH) model and move towards value-based reimbursement.	Y	-	$ 217,500	$ 2,175,000
25	8	Medicaid	Medical Care	**Clinical Quality Measurement Web-Based Viewer:** This funding will assist Patient Centered Medical Homes (PCMH) to be able to review patient level quality measures for care delivery through Truven's Provider Performance Assessment web based viewer.	Y	-	$ 36,600	$ 366,000
26	MEDICAID SUBTOTAL					-	$ 11,026,200	$ 56,937,800
27	7	Public Health	Admin	**Funding to continue Expanded Access Program for Epidiolex:** These funds will be used to maintain 38 Idaho children with intractible epilepsy in the Expanded Access Program	Y	-	$ 26,800	$ 26,800
28	PUBLIC HEALTH SUBTOTAL					-	$ 26,800	$ 26,800
29								
30	TOTAL					-	$ 11,746,000	$ 58,234,000
31								
32								
33								
55								

DEPARTMENT OF HEALTH & WELFARE
FY19 Proposed Decision Units

MAINTENANCE

DRAFT - FOR DISCUSSION PURPOSES ONLY

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Dept. Priority/DU #	Division	Program	Description	One Time	FTP	Funding General	Funding Total
10.75	Behavioral Health	SHS	FMAP rate change	N	-	TBD	TBD
	BEHAVIORAL HEALTH SUBTOTAL				-	$ -	$ -
10.75	FACS	CWS	FMAP rate change	N	-	TBD	TBD
10.75	FACS	SW.TC	FMAP rate change	N	-	TBD	TBD
10.5X TBD	FACS		Child Welfare Social Workers and Supervisors: Annualization			$ 235,800	$ 471,600
	FACS SUBTOTAL				-	$ 235,800	$ 471,600
10.75	Medicaid	Financial Operations	FMAP rate change	N	-	TBD	TBD
10.76	Medicaid	Financial Operations	Receipt reduction	N	-	TBD	TBD
10.5X 29	Medicaid	Financial Operations	Supported Living Services Rate Changes - Annualization	N	-	TBD	TBD
10.5X TBD	Medicaid	Financial Operations	Personal Assistance Services Rate Changes - Annualization	N	-	TBD	TBD
10.5X TBD	Medicaid	Financial Operations	Children's Developmental Disability Agency Rate Changes - Annualization	N	-	TBD	TBD
10.71 through 10.74	Medicaid	Financial Operations	Medicaid cost based pricing, mandatory pricing, caseload, and utilization	N	-	TBD	TBD
	MEDICAID SUBTOTAL				-	$ -	$ -
10.77	Welfare	AABD Cash	AABD Cash caseload annual growth	N		$ 636,300	$ 636,300
	WELFARE SUBTOTAL				-	$ 636,300	$ 636,300
	TOTAL				-	$ 872,100	$ 1,107,900

DEPARTMENT OF HEALTH & WELFARE
FY19 Proposed Decision Units

LINE ITEMS

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Dept. Priority/DU #	Division	Program	Description	One Time	FTP	Funding General	Funding Total
2	Behavioral Health	AMH	**Crisis Center request for Regions 2, 3, and 6:** The Division of Behavioral Health is requesting the funding necessary to contract for the operation and startup of three behavioral health community crisis centers in addition to four centers already funded.	Both	-	$ 5,160,000	$ 5,160,000
10	Behavioral Health	CMH	**YES Project - Transfer GF to Medicaid:**	N	-	$ (1,181,600)	$ (1,181,600)
22	Behavioral Health	SHN	**Change Physicians to non-classified:**	N	-	$ 30,900	$ 30,900
22	Behavioral Health	SIIS	**Change Physicians to non-classified:**	N	-	$ 23,200	$ 23,200
31	Behavioral Health	SUD	**IROC Federal Authority:** A federal grant aimed at prevention and treatment of the growing opioid addiction in Idaho and across the Nation. The grant is called Idaho's Response to the Opioid Crisis or IROC. The non-competitive federal grant is part of the Cures Act and has already been awarded to Idaho.	N		$ -	$ 1,955,000
40	Behavioral Health	SHN	**Automated Medication Storage Systems:** State Hospital North (SHN) is requesting funds to purchase two automated medication storage systems. These units would be located on each patient unit and provide nursing with an accurate medication storage and dispensing system for narcotics and ward stock items.	Y	-	$ 40,800	$ 40,800
41	Behavioral Health	SHN	**FTP and funding for Health Information Manager:** The individual will hold certification as a Registered Health Information Technician (RHIT) or Registered Health Information Administrator (RHIA), and will provide oversight of the Health Information Management functions within State Hospital North.	N	1.00	$ 72,600	$ 72,600
42	Behavioral Health	SHN	**SHN Infection Prevention Officer:** FTP and funding for Registered Nurse, SR for the Infection Prevention Officer	N	1.00	$ 77,400	$ 77,400
TBD	Behavioral Health	SHS	**SHS Staffing Request** FTP and funding for Health Information Specialist and Admin Assistant position	N	2.00	$ 101,400	$ 101,400
TBD	Behavioral Health	SHS	**SHS Reclassify LPN's to RN's**	N		$ 92,000	$ 92,000
TBD	Behavioral Health	SHS	**SHS Advanced Physical Skills Training**	Y		$ 30,000	$ 30,000
TBD	Behavioral Health	SHS	**SHS Hydraulic Kit**	Y		$ 6,000	$ 6,000
TBD	Behavioral Health	CH	**Community Mental Health:** Add intent language to be able to transfer in excess of 10%	N	-	$ -	$ -
BEHAVIORAL HEALTH SUBTOTAL					4.00	$ 4,454,900	$ 6,409,900
4	FACS	Automated Systems	**Redevelop Child Welfare Information System (Phase 3):** The third year of a five year project to modernize the Division's Child Welfare Information System and improve its mobile technology capacity.	Y	-	$ 3,900,000	$ 7,800,000
33	FACS	DD	**Early & Periodic Screening, Diagnostic and Treatment (EPSDT) State Plan Amendment (SPA):** The establishment of this defined Medicaid benefit will allow the program to use increased resources to eliminate of the program's waiting list, decrease contractor turnover, provide needed services to infants and toddlers, and ultimately meet federal requirements.	N	-	$ 321,100	$ 1,129,800
FACS SUBTOTAL					-	$ 4,221,100	$ 8,929,800

DEPARTMENT OF HEALTH & WELFARE
FY19 Proposed Decision Units

LINE ITEMS

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Dept. Priority/DU #	Division	Program	Description	One Time	FTP	Funding General	Total
13	Healthcare Policy Initiatives		Statewide Healthcare Innovation Plan (SHIP) This request is for an additional $5,000,000 in federal spending authority for the period of 7/1/2018-6/30/2019 to continue implementation of the Statewide Healthcare Innovation Plan (SHIP) for SFY2019.	Y			$ 5,000,000
HEALTHCARE POLICY INITIATIVES SUBTOTAL					-	$ -	$ 5,000,000
15	Licensing & Certification	RALF	3 Additional Health Facility Surveyors: Currently, there are 276 licensed facilities with 359 total buildings and 9,912 licensed beds. The RALF program oversees those 9,912 licensed beds with 9 permanent Health Facility Surveyors. This translates to 1,101 licensed beds per surveyor.	N	3.00	$ 91,400	$ 276,900
LICENSING & CERTIFICATION SUBTOTAL					3.00	$ 91,400	$ 276,900
1	Medicaid	Medicaid	Idaho Health Care Plan (TBD):	N	-	$ -	$ -
8	Medicaid	Administration	Medicaid Management Information System (MMIS) Independent Verification and Validation (IV&V): This request covers the cost to pay for the Centers for Medicare and Medicaid (CMS) required Independent Verification and Validation (IV&V) vendor. The IV&V will provide an independent and unbiased perspective on the progress of MMIS system development and the integrity and functionality of the system.	Y	-	$ 200,000	$ 2,000,000
10	Medicaid		YES Project - Transfer GF from CMH:	N	-	$ 1,161,600	$ 1,161,600
12	Medicaid	Medical Care	Clinical Quality Measurement System Development: For connecting Medicaid Patient Centered Medical Home (PCMH) providers to Idaho's Health Information Exchange (HIE).	Y	-	$ 230,000	$ 2,300,000
12	Medicaid	Medical Care	Clinical Quality Measurement Web-Based Viewer Maintenance: For the implementation of advanced analytics and display capabilities through a web based Medicaid Management Information System (MMIS) portal.	N	-	$ 126,500	$ 253,000
18	Medicaid	Administration	Medicaid Personnel and Operating Request: The first position is needed to manage the work to transition our Medicaid Management Information System (MMIS) to a modular systems approach as required by federal regulations. The second position will support a higher standard of financial forecasting and modeling for the Medicaid budget to ensure accurate budget projections The third and forth positions are needed to support program analysis reporting and contract monitoring activities for Regional Care Organizations (RCO) to further Medicaid's strategic objectives to transform the state's primary care landscape towards value-based payment reform. We are also requesting one-time marketing funds for RCO communication to operationalize Medicaid's strategic objectives to transform the state's primary care landscape towards value-based payment reform. We expect all expenditures related to implementation of value-based payment strategies to be fully offset by decreases in trustee and benefit spending. The fifth and sixth positions are limited service positions and are needed to support the Youth Empowerment Services (YES) program through 2020. Implementation of the YES program is a multi-divisional including automated system changes as well as contracting effors.	Both	6.00	$ 286,100	$ 612,400

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33	Medicaid		**Early & Periodic Screening, Diagnostic and Treatment (EPSDT) State Plan Amendment (SPA):** The establishment of this defined Medicaid benefit will allow the program to use increased resources to eliminate of the program's waiting list, decrease contractor turnover, provide needed services to infants and toddlers, and ultimately meet federal requirements.	N	-	$ (321,100)	$ (1,126,700)
40	Medicaid	Financial Operations	**Technical Records Specialists for the Office of Financial Recovery:** Currently we pay for temporary workers to perform technical records specialist duties in our federally mandated estate recovery program. We want to move the general funds from operating to personnel because we have been using this temporary service for multiple years. The work is not considered temporary anymore and the general fund cost is about the same.	N	2.00	$ 18,200	$ 36,400
43	Medicaid	Medical Care/ TSS	**Medicaid External Quality Review (EQR):** To cover the cost to pay for required External Quality Review (EQR) for our managed care contracts. Medicaid is federally required to conduct this review for our Idaho Behavioral Health Plan, Dental Plan, and Medicare-Medicaid Coordinated Plan(s).	N	-	$ 240,000	$ 480,000
44	Medicaid	LTSS	**Aid to the Aged, Blind, and Disabled Program (AABD) Rule Change:** The initial PNA was set at $40 per month over 20 years ago. With the cost of goods and services going up each year over the last 20 years, it is time to increase this amount to $55, so the participant can purchase personal items each month. On average, 3,740 participants have skilled nursing facility coverage each month. If this request is approved, participants will retain more of their monies to use for personal items and services, which will reduce their share of cost amounts – resulting in a department responsibility of an estimated $486,600 per year for Medicaid claims.	N	-	$ 139,000	$ 4
MEDICAID SUBTOTAL					**8.00**	**$ 2,080,300**	**$ 6,223,300**
17	Public Health	Food Protection Program	**Food Protection Program FTP:** Health Program Specialist (class M) to ensure staffing capacity within the Food Protection Program and increase standardization in retail food inspection practices in Public Health Districts. Increases temp position from 0.66 FTP to 1.0 FTP.	Ongoing	1.00	$ 26,300	$ 26,300
21	Public Health	BVRHS	**Electronic Death Registration System (EDRS) Modernization:** The computer language Idaho's EDR is written in is no longer the industry standard. At this time, the language can be updated as a less expensive option compared to replacing the system and will extend the application's lifespan. If the application language is not updated the system will cease to work with commercially available web browsers, effectively eliminating the usefulness of the system.	N	-	$ 75,000	$ 75,000
23	Public Health	Immunization Program	**TRICARE Funding:** Funding to pay for TRICARE - covered children vaccines. These funds will be used to cover the potential gap in vaccine funding created by TRICARE's continued refusal to participate in the Idaho Vaccine Assessment Fund.	Y	-	$ 613,000	$ 613,000
24	Public Health	BRHPC	**Rural Health Research Analyst:** A .33 FTP increase for a Research Analyst responsible for data collection and analysis to determine Health Professional Shortage Areas (HPSA). The federal requirements for states to collect and analyze data to determine HPSAs has significantly increased.	N	0.33	$ -	$ 19,900

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1								
2				DEPARTMENT OF HEALTH & WELFARE				
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8	Priority/DU #	Division	Program	Description	Time	FTP	General	Total
45	25	Public Health	WIC	e-WIC Program Specialist FTP: FTP for Health Program Specialist classification; help implement, coordinate, and evaluate e-WIC. The program is federally required to transition from paper benefits to electronic benefits (eWIC) by 2020.	N	1.00	$ -	$ 77,400
46	26	Public Health	BOCAPS	Clinical Services Health Education Specialist: FTE for Health Education Specialist classification; help bureau with education and outreach activities	N	1.00	$ -	$ 69,600
47	32	Public Health	Suicide Prevention Program	Youth Suicide Prevention: The Suicide Prevention Program currently provides the evidence-based program, ongoing wellness and suicide prevention program – Sources of Strength (Sources) – in middle, junior, and senior high schools in Idaho. The additional $523,800 requested would allow expansion of this program into 25 new Idaho public schools per year and allow for a pilot evidence-based program called the Good Behavior Game (GBG) to be implemented in Idaho public elementary schools that feed into the Sources schools	N	-	$ 523,800	$ 523,800
48	38	Public Health	BCEH	Idaho Hospital Association Cancer Data Registry of Idaho (CDRI): The CDRI is the only source for population-based cancer statistics and cancer survival statistics among Idahoans. The Bureau of Community and Environmental Health has been cobbling together funding over the last several years to keep CDRI at level funding. However, with the uncertainty of federal funds and the continued need for population-based cancer statistics, ongoing general funds are needed to secure and complete the work.	N	-	$ 106,000	$ 106,000
49	37	Public Health	EMSP	Increase receipt authority for Time Sensitive Emergency (TSE): The spending authority for TSE Receipts is currently $127,000. It is anticipated that the program receipts will exceed the current spending authority. This request is to increase receipt spending authority to $200,000; to allow the program to operate on program receipts.	N	-	$ -	$ 200,000
50	TBD	Public Health	BOCAPS	Critical Congenital Heart Disease: to cover operating costs to add Critical Congenital Heart Defect (CCHD) screening to the newborn screening rules.	N	-	$ 20,000	$ 20,000
51	TBD	Public Health	BVRHS	Vital Statistics Receipt Authority Transfer: The Bureau of Vital Records & Health Statistics is requesting an ongoing transfer of $120,000 in receipt authority from Trustee & Benefits (T&B) to support personnel expenditures. The existing Trustee & Benefits authority is within the Physical Health Services appropriation.	N	-	$ -	$ -
52	TBD-1	Public Health	Administration	Advance Directive Programming; Support for Honoring Choices Idaho (HCI) Program: Focus on expanding the service area statewide.	Y	-	$ 554,600	$ 554,600
53	TBD-1	Public Health	Administration	Advance Directives Registry FTE; administration of registry: Three staff to support the registry contracts, use, hospital coordination, etc.	N	3.00	$ 235,600	$ 235,600

DEPARTMENT OF HEALTH & WELFARE
FY19 Proposed Decision Units

LINE ITEMS

DRAFT - FOR DISCUSSION PURPOSES ONLY

Date / Time: 8/16/17 5:57 PM

Dept. Priority/DU #	Division	Program	Description	One Time	FTP	Funding General	Total
TBD-1	Public Health	Administration	**Advance Directive Marketing Campaign:** A marketing campaign needs to focus on driving providers of care (faith based, skilled nursing, physicians of all disciplines, YMCA, etc.) to have the conversations with their patients/clients about completing advance directives and POST forms	N	-	$ 200,000	$ 200,000
TBD-1	Public Health	Administration	**Advance Directives Registry:** Cost includes annual license, conversion of existing registry records to new system (assuming 32,000 records), one-time perpetual license.	Y	-	$ 179,500	$ 179,500
	PUBLIC HEALTH SUBTOTAL				6.33	$ 2,533,800	$ 2,900,900
14	Support Services	IT	**IT Security applications:** Increased cost of maintenance and service agreements over the last 4 years - Cisco Security	N	-	$ 784,000	$ 1,400,000
16	Support Services	IT	**SCO Mainframe Costs:**	N	-	TBD	TBD
19	Support Services	Criminal History Unit	**Criminal History Unit (CHU) Staffing and Equipment:** The Bureau of Audit and Investigations Criminal History Unit (CHU) is requesting two full-time positions, operating costs and receipt authority of $134,600 in order to satisfactorily meet the increased demand for its services.	Both	2.00	$ 7,200	$ 135,600
26	Support Services	Medicaid Program Integrity Unit	**Medicaid Program Integrity Unit (MPIU) Staffing:** This requested position is to fulfill two administrative functions: a) preparing legal documents for recovering uncollectable debts through asset recovery and b) preparing legal records for exclusions and terminations. This individual will prepare court documents needed to obtain court judgments on outstanding provider debts.	Both	1.00	$ -	$ 6[illegible]00
27	Support Services	Fraud Analysis	**Medicaid Program Integrity Unit (MPIU) Fraud Analysis Staffing:** There is an increased ROI seen in partnering units, such as Medicaid Program Integrity Unit (MPIU), when data analysis is used during an investigation. Such analytics provide auditors with targeted, high value leads upon which to focus their investigation.	Both	1.00	$ -	$ 66,700
30	Support Services	Operational Services	**Potential move - CdA:** Move related costs for new CdA Facility - cubicle walls, moving expenses, misc., etc.	Y	-	$ 182,000	$ 349,100
TBD	Support Services	IT	**ITSD Staffing:** The resources requested will provide critical support to all agency personnel who utilize the systems required by the various programs in this regard. Maintaining adequate staffing allows us to provide the much-needed enhancements or improvements to these information systems	Both	4.00	$ 153,300	$ 383,300
TBD	Support Services	IT	**Software Licenses:** 2,000 licenses for Microsoft Enterprise Mobility Suite + Security. This software enables DHW to control content of mobile devices (smartphones, tablets and laptops) indicating whether a document can be printed, shared or saved to an external device, even when the device is not on the DHW network. 3,600 licenses for Ivanti Performance Manager software. This product will enable IT teams to centrally control resources for all application and desktop delivery methods while reducing hardware costs and increasing performance	Both	-	$ 133,800	$ 241,000

DEPARTMENT OF HEALTH & WELFARE
FY19 Proposed Decision Units

LINE ITEMS

DRAFT - FOR DISCUSSION PURPOSES ONLY

Date / Time: 8/16/17 5:57 PM

Dept. Priority/DU #	Division	Program	Description	One Time	FTP	Funding General	Funding Total
TBD	Support Services	IT	ITSD Targeted Class Salary Increases: To increase the compensation rate for three Information Technology (IT) classifications by 12% to mid-range or policy, in an effort to minimize the impact to our agency and division in obtaining and retaining skilled IT personnel. The Department has experienced significant difficulties in recruiting, hiring, and retaining qualified individuals due to increased competition with the private sector and the current state compensation schedule.	N	-	$ 104,500	$ 261,200
SUPPORT SERVICES SUBTOTAL					8.00	$ 1,364,800	$ 2,896,500
5	Welfare	Child Suppor	Child Support Automated System Modernization (year 3 of 3 year project): Year 3 of the Child Support modernization effort will see additional revisions to CS functionality using automation development and business re-engineering that has been the key to the Division of Welfare's service delivery success.	Y	-	$ 2,720,000	$ 8,000,000
6	Welfare	SNAP	Employment and Training (E&T): USDA/FNS 50/50 funding for Employment & Training (federal authority only - match to partners)	N	-	$ -	$ 2,000,000
44	Welfare	AABD	Aid to the Aged, Blind, and Disabled Program (AABD) Rule Change: This request is for $35,800 (rounded) in state general funds to increase the Aid to the Aged, Blind, and Disabled Program (AABD) cash benefit received by a disabled individual residing in a nursing home to help cover personal needs from $10 a month to $25 a month, a $15 per month increase. There is no matching federal funds for this request as the AABD Cash program is 100% state funded.	N	-	$ 35,800	$ 35,800
TBD-2	Welfare	Child Support	Ongoing transfer of Personnel dollars to Operating to support ongoing maintenance of new Child Support system: FTP authority (10.05) to FACS, funds stay in S/R	N	-	$ 209,100	$ 615,000
TBD-2	Welfare	Child Support	Ongoing transfer of Personnel dollars to Operating to support ongoing maintenance of new Child Support system: FTP authority (10.05) to FACS; funds stay in S/R	N	-	$ (709,100)	$ (615,000)
WELFARE SUBTOTAL					-	$ 2,755,800	$ 10,035,800
TOTAL					29.33	$ 17,502,100	$ 42,673,100

ATTACHMENT 11

Strategic Plan SFY 2018 - 2022
Overview (Last revision 5/11/17)

IDAHO DEPARTMENT OF HEALTH & WELFARE

Governor's Priorities
- *Enhancing Economic Opportunity*
- *Empowering Idahoans*
- *Promoting Responsible Government*

DHW Vision:
Provide leadership for development and implementation of a sustainable, integrated health and human services system

DHW Mission:
Promote and protect the health and safety of Idahoans

DHW Values:
Integrity, high quality customer service, and compassion are the foundation for all Department activities. A focus on these values will lead to success

DHW Strategic Goals:
- **Goal #1:** *Improve the health status of Idahoans*
- **Goal #2:** *Increase the safety and self-sufficiency of individuals and families*
- **Goal #3:** *Enhance the delivery of health and human services*

Strategic Objectives

	Objective #1	Objective #2	Objective #3
	Transform Idaho's health care delivery system to improve Idaho's health and increase value	***Protect children and vulnerable adults***	***Promote stable and healthy individuals, families and populations through medical coverage, program access, support services and policy***
DELIVERY SYSTEM STRATEGIC INITIATIVES	*Transform Idaho's Healthcare Delivery and Reimbursement Systems* *Address Gap Population Health Care and Access Needs* *Implement Youth Empowerment Services System of Care*	*Ensure Long-term Residential Care for Individuals with Chronic Mental Illness* *Transform Child Welfare Systems to Improve Outcomes for Children* *Develop a Therapeutic Stabilization and Transition Center for Clients with Developmental Disabilities*	*Implement Comprehensive Suicide Prevention Strategies* *Develop System for Comprehensive Oversight of Delivery of Services to Individuals with Developmental Disabilities*
SUPPORT SYSTEM STRATEGIC INITIATIVES	*Integrate Information Systems and Enhance System Security* *Be A Catalyst for Implementation of a New Statewide Accounting System* *"Live Better Idaho" Initiative*		

ATTACHMENT 12

IDAHO DEPARTMENT OF HEALTH & WELFARE

Strategic Initiatives – SFY 2018 through 2022

Description and Leads

Strategic Initiative:
Transform Idaho's clinical delivery system by implementing the Statewide Health Care Innovation Plan and implement value-based payment systems within Medicaid.

Lead: Cynthia York

Initiative Description:
Two broad initiatives are included within this initiative. First, the Idaho Statewide Healthcare Innovation Plan (SHIP) is designed to improve access to care for all Idahoans, make them healthier, and lower overall healthcare costs. The process to develop the plan involved hundreds of Idahoans from across the state, including private and public payers, legislators, health system leaders, primary care providers, nurses, healthcare associations, tribal health clinics, and community members. SHIP's goal is to transform Idaho's healthcare system from a fee-for-service, volume-based system to a value-based system of care that rewards improved health outcomes. Critical to improving outcomes rather than just temporarily reducing costs will be the expansion of adoption of the Patient Centered Medical Home model among primary-care providers while implementing the support structures and reimbursement changes necessary for their success.

Second is the transition of Medicaid reimbursements into value-based payment systems. Value-based payments are designed to change how healthcare is organized and delivered by changing how healthcare services are reimbursed. This multi-year activity will partner with accountable-care entities to transition networks of providers into delivery systems that focuses on whole-person care while responsibly managing resources. This activity will build upon the state's PCMH efforts through the inclusion of specialists, hospitals and other providers within these accountable networks.

Performance Measures:

- By August 2018, enhance the Medicaid Patient Centered Medical Home program to include a shared-savings component in support of primary-care transformation.
- By December 31, 2018, design episode-of care payment bundles for Medicaid in support of specialty physician transformation. Implement at least one category of bundles, such as maternity or orthopedics

- By Januarynary practices in Idaho to certified Patient-centered M
- By Januaryls to the Idaho Health Data Exchange (IHDE)
- By Januaryal PCMHs in rural communities
- By Januaryted PCMHs have access to statewide data analytics
- By Januarynal Collaboratives to provide quality improvemeighborhood integration services
- By Januaryh providers, health systems and industry experts in ebased payment systems for use by Idaho Medicaid. Design by September 2017.
- Work outsiwith provider systems and commercial payers, explue-based programs and creating a critical mass neceiwho are transforming their business mode
- By Januaryary practices in Idaho to certified Patient-centered M
- By Decemlt least one Regional Care Organization (RCO) in sansformation.

Strategic Initiativ
Address Gap Popccess Needs

Lead: Lisa Hetti

Initiative Descripti
With this initiativelutions to provide health care coverage for the "gap" populatin Workgroup established by Gov. Otter recommended thigibility requirements for the 78,000 Idahoans who maf the federal poverty level because they don't make enoulp pay for insurance on the state-based exchange, and thy for health insurance outright. There is no consensus amont that expanding Medicaid is the best solution. The Dej work with policy makers to explore options and develop soluige for this population.

Performance Mea
- Reductionh care costs
- Number ofine sources of care

Strategic Initiative:
Implement Youth Empowerment Services (YES) System of Care

Lead: Ross Edmunds

Initiative Description:
With this initiative, the Department will develop and implement a children's mental health system of care (SoC) that is community-based, easily accessed and family-driven and operates with other features consistent with the System of Care Values and Principles.

Performance Measures:

- By 12/31/2018, implement the Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment[1] to establish a threshold of current class member functional impairment and levels of care
- By 9/30/2019, complete an evaluation of CANS to determine changes in functional impairment as a result of the treatment and support delivered under the Youth Empowerment Services (YES) system of care
- By 1/31/2020, develop a Quality Management, Improvement, and Accountability Plan and full system performance measures
- By 12/31/2020, complete all Jeff D. implementation plan action items

Strategic Initiative:
Develop a Therapeutic Stabilization and Transition Center for Clients with Developmental Disabilities

Lead: Miren Unsworth

Initiative Description:
The courts continue to assign DHW with the care of individuals who are severely developmentally disabled and who are a threat to themselves and/or others. The Department is in the process of securing the proper facilities and developing the services to adequately care for and treat this population as well as developing rules to establish a new facility type and the state licensing requirements.
Performance Measures:

- By July 1, 2018, establish a new facility type, Secure Treatment Facility, and the state licensing requirements for the new facility type
- By July 1, 2018, establish a Secure Treatment Facility for people with developmental disabilities and mental illness requiring short-term or crisis stabilization

[1] The CANS Assessment is a multi- purpose tool developed to support care planning and level of care decision-making, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

- By July 1, 2020, develop the capacity for safe evaluation and treatment of individuals committed to the Department for placement, evaluation, and competency training

Strategic Initiative:
Ensure Long-term Residential Care for Individuals with Chronic Mental Illness

Lead: Ross Edmunds

Initiative Description:
Idaho struggles to meet the needs of its citizens with mental illness whose illness is not severe enough to require hospitalization but who also can't live independently because of their illness. Individuals with mental illness are often housed in assisted living facilities that are not well-equipped to meet their mental health needs. The appropriate model for providing the level of support necessary to safely manage and effectively treat patients with mental illness of a certain severity does not exist in Idaho. This strategic initiative is designed to establish a best practice model to meet the needs of this population and those who care for them.

Performance Measures:
- By July 1, 2018, pilot a new residential setting, Homes for Adult Residential Treatment (HART), in at least three different locations in the state that provides more cost effective treatment than currently financed by the state to support Idahoans with serious mental illness who cannot live independently
- By July 1, 2018, implement a mechanism to adequately reimburse providers for the treatment and support of Idahoans with serious mental illness to save the state more expensive treatment elsewhere
- By July 1, 2020, construct a Nursing Home, on the State Hospital South campus, that adequately meets the needs of the those who qualify for nursing home care, with behavioral health needs, 65 years of age or older

Strategic Initiative:
Transform Child Welfare Systems to Improve Outcomes for Children

Lead: Miren Unsworth

Initiative Description:
This initiative involves several projects which include many stakeholders and partners. It involves changing and streamlining processes, enhancing Department infrastructure, improved coordination with critical stakeholders and partners (such as law enforcement, education, courts, tribes, and the medical and behavioral health communities), upgrading technology, improved programs (such as the foster care program), and legal representation for the Department in court. This initiative is important as we strive to gain better long-term outcomes for today's children in care. These children today are

the adults of tomorrow who will either be in prison, on the streets, or in professional careers leading productive lives with healthy families of their own. Society as a whole can be better with the successful completion of this initiative. If we don't complete it, there are higher costs to tax payers, and higher emotional prices paid by children that will continue to plague them into adulthood.

Performance Measures:

- By July 1, 2018, the Department will advance legislation to obtain party status in child protection cases and ensure consistent agency representation in child protection cases.
- By July 1, 2019, ensure timeliness of initiating safety assessments (both response time and timeliness in seeing the child(ren)) as outlined in IDAPA 16.06.01.554 at or above 88.5%.
- By July 1, 2020, increase response rates to our resource parent annual surveys from 10-15% to 30-40%.
- By July 1, 2020, increase the number of youth age 14 and over who have completed a life skills assessment within 90 days of eligibility to 80% or above and increase the number of youth with an independent living plan to 68% percent within 90 days of eligibility.
- By July 1, 2020, maintain or increase placement stability to higher than the federal outcome standard (4.12 moves per 1,000 days in care)
- By July 1, 2020, decrease turnover rates among child welfare social workers and supervisors from 10-15% to 5-10%.
- By July 1, 2020, increase the response rates to staff surveys and evaluations on effectiveness and satisfaction of trainings and resources offered from 25-45% to 60-80%.
- By July 1, 2020, maintain or reduce re-entries into foster care to below the federal outcome standard (8.3%)
- By July 1, 2020, maintain or reduce instances of repeat maltreatment to below the federal outcome standard (9.1%)
- By July 1, 2020, the program will have sustained improvement at or above 90% on the program's goal for Family Involvement in Case Planning from the results of the program's Case Record Reviews
- By July 1, 2020, the program will increase response rates to stakeholder surveys from 10- 20% to 30 -40%.
- By July 1, 2020, the program will ensure early and timely permanency for all children in foster care (maximums -- 12 months to reunification, 13 months to guardianship, or 24 months to adoption per state statute)

ATTACHMENT 13

Strategic Initiative:
Implement Comprehensive Suicide Prevention Strategies

Lead: Elke Shaw-Tulloch

Initiative Description:
With this initiative, the Department will convene stakeholders and lead the efforts to implement the State Suicide Prevention Plan. The Idaho Suicide Prevention Plan is intended to empower communities in providing suicide prevention, intervention and response to suicide attempts and completions.

Performance Measures:

- By July 1, 2018, air public awareness campaign public service announcements
- By July 1, 2018, distribute public awareness campaign collateral materials statewide
- By July 1, 2018, five Zero Suicide Health System Partners have developed and/or implemented Zero Suicide action plans
- By July 1, 2018, 50 behavioral health clinicians have been training in suicide assessment and management
- By July 1, 2018, provide 10 suicide prevention gatekeeper trainings to professionals and community members
- By July 1, 2018, provide suicide survivor packets to survivors of suicide loss
- By July 1, 2018, provide materials about suicide prevention and lethal means to 20% of Idaho gun shops, gun ranges and firearms instructors
- By July 1, 2018, commit ongoing financial support to the Idaho Suicide Prevention Hotline
- By July 1, 2018, provide training in life-long resilience and well-being to 25% of middle and high schools

Strategic Initiative:
Develop the System for Comprehensive Oversight of Delivery of Services to Individuals with Developmental Disabilities

Leads: Miren Unsworth and Matt Wimmer

Initiative Description:
Currently, services for individuals with developmental disabilities are managed and delivered from different organizational units within the Department. This initiative will focus on examining current processes to better coordinate services and gain efficiencies and possible cost savings as well as ensuring we are delivering services to this population in a comprehensive manner from birth through adulthood.

Performance Measures:

- Gaps in services for individuals transitioning between early intervention and children's services are at 0%. Occurrence of gaps in services between children and adult programs should not exceed 5%.
- Development, implementation, and publication of DD specific QA/QI measures across the lifespan and services array
- Increased collaboration and formal agreements between Department DD Programs and other DD Programs such as Adult Protection and Vocational Rehabilitation
- Development of efficient and understandable description and entry tools allowing individuals' easier access to services and supports
- By July 1, 2018, finalize a five-year plan for developmental disability services with the input of participants, providers, and community advocates

Strategic Initiative:
Integration of Information Systems

Lead: Michael Farley

Initiative Description:
With this initiative, the Department will develop and implement policies and technology that integrate data across organizational units.

Performance Measures:

- By July 1, 2020, decommission redundant and outdated software and technology or move to an improved technological platform
- By July 1, 2020, consolidate servers and technology
- By July 1, 2020, eliminate obsolete rules engines
- By July 1, 2020, consolidate web application firewalls
- By July 1, 2020, consolidate perimeter firewalls

Strategic Initiative:
Be a catalyst for implementation of a new statewide accounting system.

Lead: Dave Taylor

Initiative Description:
With this initiative the Department will coordinate with the Office of the State Controller (SCO), the Division of Financial Management (DFM), and the Legislative Services Office (LSO) as the state works toward the possible replacement of both the Department's and the State of Idaho's accounting system. The purpose of this coordination is to create an environment that mitigates risks typically associated with a significant change in a state's multi-agency accounting infrastructure.

Performance Measures:

- Continue to work with SCO, DFM and LSO in Idaho's statewide accounting modernization planning and development efforts
- Continue to develop, document, and analyze "as is" and "to be" documentation for the Department's most critical administrative and financial business processes
- Continue to coordinate, analyze, and support the effort to identify the future state requirements for the core administrative and financial systems statewide alongside SCO, DFM, and LSO
- Complete the design and documentation of a future state-wide chart of accounts alongside SCO, DFM, and LSO
- Determine and implement the organizational structure within the Department's Office of Financial Services necessary to support the current as-is business processes, as well as the needs of the Idaho Statewide Infrastructure Modernization (ISIM) project
- Start preparing for the migration of the Department's financial data by executing the following:
    - Analysis of current financial data
    - Documentation of data conversion risk assessment for all automated financial system processes
        Example: cleansing of invalid vendor records
    - Implement clear agency-wide expectations and/or standards for critical areas of anticipated data conversion
        Example: vendor/payee records management

Note: Target dates for the above measures have not been set as those dates are dependent on the Department's partners in this initiative.

Strategic Initiative:
"Live Better Idaho" Initiative

Lead: Lori Wolff

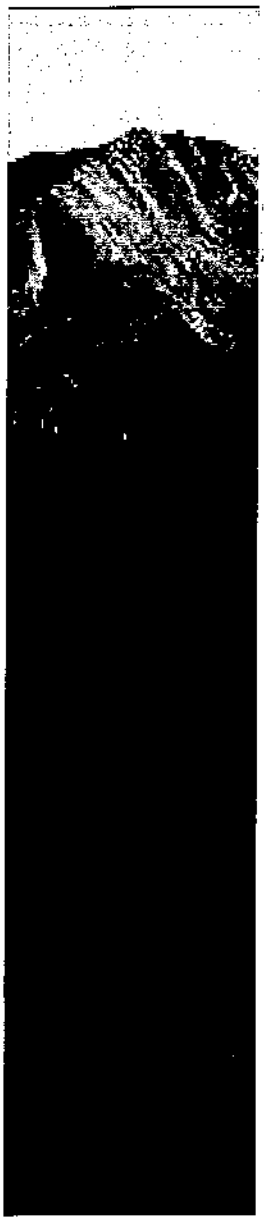
Initiative Description:
With this initiative, the Department will address the following priorities:

- To provide a useful and relevant virtual connection to services by creating a consumer-focused, goal-oriented site, where a consumer can find the services that connect and serve their families. This concept would cross divisions, agencies, and community partners and would focus on services that help Idaho families live better, healthier, and more productive lives. It would identify the services from a decision to improve the quality of life, rather than an entitlement or government handout. This website also will help consumers connect beyond the walls of DHW and see that communities offer many resources and opportunities to help them "Live Better."

- To change the environment in DHW field offices, which is the place where many of the department's clients interact with staff and services. The department will create an environment where Idahoans and their families go to make informed choices about how to improve their lives and become healthier and more self-reliant. By changing the environment and focus from entitlement programs to empowerment programs, we will position our consumers and staff to help move individuals and families to stronger stability and longer term sustainability.
- Identify partnerships across agencies to help connect services that will better align education, training and employment services, and human and social services among public and agencies and employers that will create positive pathways for families to become self-reliant and successful in the workforce.

Performance Measures:

- By July 1, 2018, improve consumer access to information and services through the web
- By July 1, 2018, improve culture and conversation through customer interactions on the phone
- By July 1, 2018, create new focus on nutrition, health, and improved lifestyle in offices and through written materials
- By July 1, 2018, develop partnerships with other agencies to identify services that align with the vision of Live Better Idaho and develop a community of resources and information that inform and empower Idaho families and citizens in a positive way
- By July 1, 2018, all divisions within the Department of Health and Welfare will make relevant services available to customers on the Live Better Idaho site



IDAHO Department of Health and Welfare

Strategic Plan
SFY 2018 – 2022

"Promote and protect the Health and safety of Idahoans

July 1, 2017

www.healthandwelfare.Idaho.gov

IDAHO DEPARTMENT OF HEALTH & WELFARE

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSHILL S. BARRON – Director

OFFICE OF THE DIRECTOR
450 West State Street, 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-5500
FAX 208 334 5926

July 1, 2017

Dear Citizens,

I am pleased to present the 2018-2022 Strategic Plan for the Idaho Department of Health and Welfare.

Our agency is dedicated to protecting the social, economic, mental and physical health, and safety of Idahoans, while promoting healthy behaviors and positive lifestyles. We provide critical and valued services to more than a third of all Idahoans, and we strive to be a vital partner to other agencies and communities in our state, both in leadership and supportive roles.

As we embark upon the future, we have instituted several important strategic initiatives and opportunities for our state to help strengthen Idaho citizens and families while improving their health and self-sufficiency.

Foremost among these is the extraordinary effort to transform Idaho's healthcare delivery system. A major contributor to this initiative is the Statewide Healthcare Innovation Plan (SHIP). This four-year initiative began in February 2015 and is a plan to improve access to care for all Idahoans, make them healthier, and decrease overall healthcare costs. A new, critical piece is the Medicaid reimbursement transformation which will serve as the department's payer contribution to transforming Idaho's healthcare system from a fee-for-service, volume-based system to a value-based system of care that rewards improved health outcomes.

In our effort to improve Idaho's health and increase value for Idahoans, we continue our work in implementing the Youth Empowerment Services (YES) System of Care. This initiative seeks to develop and implement a children's mental health system of care that is community-based, easily accessed, and family-driven.

We also continue to engage important community partners and lawmakers to develop a solution for uninsured, low-income adults who are in an insurance "gap." These adults earn too much income to qualify for Medicaid coverage but too little to qualify for a federal tax credit to purchase insurance on the state-based health insurance exchange. An estimated 78,000 Idaho adults have no insurance coverage options. Most of them are employed, and many are veterans. They are either going without care or relying on

some form of charity care to get by. In Idaho, we are determined to create a solution for these citizens.

Other strategic initiatives we are focused on include:

- Transforming the child welfare system to improve outcomes for children. This includes more in-home services for at-risk families, reducing the time it takes to place a child in a permanent home, and improved coordination with partners, such as foster families, police, and the courts.
- Implementing comprehensive suicide prevention strategies in Idaho. Through the establishment of the Suicide Prevention Program, DHW will take the lead to create the Idaho Suicide Prevention Plan goals with various partners. The goals cover outreach and prevention, intervention, treatment, and support for families who have suffered a suicide.
- Implementing a plan for long-term residential care for citizens who have a chronic mental illness and are too often living in the shadows of society. We are planning to pilot a best-practices model to provide the level of support necessary to improve the quality of life for people who cannot live independently, but who do not require hospitalization.
- Developing a therapeutic stabilization and transition center for Idaho citizens with developmental disabilities. Our agency is in the process of securing proper facilities and developing services to care for and treat these citizens.

All of these initiatives will help Idaho citizens and families succeed despite the significant challenges they face.

As we move forward, we continue to focus on the goals and objectives outlined in this plan and work toward them. This plan is outcome-driven and we will use it to:

- Enhance our accountability to Idaho citizens and lawmakers.
- Improve our administration and delivery of services.
- Assess program effectiveness to help us plan for the future.

Our strategic plan lays the foundation for us to address state and community issues with a vision that is coordinated with our partners. The plan sets a prioritized timeline for meeting measurable objectives to attain goals that better serve the people of our state. The department is committed to deliver services that provide for the safety and well-being of Idaho's children and families. This strategic plan continues to be the road map for our journey.

Sincerely,

Russell S. Barron

Russell S. Barron
Director

IDAHO DEPARTMENT OF HEALTH & WELFARE

Strategic Plan Overview 2018 – 2022

Governor's Priorities:

Enhancing Economic Opportunity
Empowering Idahoans
Promoting Responsible Government

DHW Vision:

Provide leadership for development and implementation of a sustainable, integrated health and human services system.

DHW Mission:

Promote and protect the health and safety of Idahoans.

DHW Values:

Integrity, high quality customer service, and compassion are the foundation for all Department activities. A focus on these values will lead to success.

DHW Strategic Goals:

Goal #1: *Improve the health status of Idahoans.*
Goal #2: *Increase the safety and self sufficiency of individuals and families.*
Goal #3: *Enhance the delivery of health and human services.*

Strategic Objectives

	Objective #1	Objective #2	Objective #3
	Transform Idaho's health care delivery system to improve Idaho's health and increase value	***Protect children and vulnerable adults***	***Promote stable and healthy individuals, families and populations through medical coverage, program access, support services and policy***
DELIVERY SYSTEM STRATEGIC INITIATIVES	*Transform Idaho's Healthcare Delivery and Reimbursement Systems* *Address Gap Population Health Care and Access Needs* *Implement Youth Empowerment Services System of Care*	*Ensure Long-term Residential Care for Individuals with Chronic Mental Illness* *Transform Child Welfare Systems to Improve Outcomes for Children* *Develop a Therapeutic Stabilization and Transition Center for Clients with Developmental Disabilities*	*Implement Comprehensive Suicide Prevention Strategies* *Develop System for Comprehensive Oversight of Delivery of Services to Individuals with Developmental Disabilities*
SUPPORT SYSTEM STRATEGIC INITIATIVES	*Integrate Information Systems and Enhance System Security* *Be a Catalyst for Implementation of a New Statewide Accounting System* *"Live Better Idaho" Initiative*		

DHW Strategic Goals:

Goal #1: *Improve the health status of Idahoans.*

Goal #2: *Increase the safety and self-sufficiency of individuals and families.*

Goal #3: *Enhance the delivery of health and human services.*

OBJECTIVE #1

Transform Idaho's health care delivery system to improve Idaho's health and increase value

Strategic Focus:

The Department's general operations are administered to ensure Idaho's health care delivery system is value-based. In an effort to provide leadership in transforming Idaho's health care delivery system, the Department will also place priority and focus on achieving the following outcomes:

- Improving health outcomes for all Idahoans
- Improving quality and patient experience of care
- Reducing health care costs
- Ensuring all Idahoans have access to comprehensive health insurance or primary/mental health care

Indicators of Success:

- Expansion of Patient Centered Medical Homes (PCMH) practices statewide
- Increased use of Electronic Health Records and Idaho Health Data Exchange
- Implementation of a statewide performance reporting and data analytics system
- Establish Regional Health Collaboratives to support coordination of PCMHs and the Medical Health Neighborhoods
- Adoption of value-based payment models to augment or replace fee-for-service payment systems
- Successful implementation of the Jeff D. settlement agreement and implementation plan

These initiatives have been launched as part of the Department's Strategic Plan toward achievement of the strategic outcomes and Objective #1. Each initiative is introduced below:

Strategic Initiative:

Transform Idaho's clinical delivery system by implementing the Statewide Health Care Innovation Plan and implement value-based payment systems within Medicaid.

Initiative Description:
Two broad initiatives are included within this initiative. First, the Idaho Statewide Healthcare Innovation Plan (SHIP) is designed to improve access to care for all Idahoans, make them healthier, and lower overall healthcare costs. The process to develop the plan involved hundreds of Idahoans from across the state, including private and public payers, legislators, health system leaders, primary care providers, nurses, healthcare associations, tribal health clinics, and community members. SHIP's goal is to transform Idaho's healthcare system from a fee-for-service, volume-based system to a value-based system of care that rewards improved health outcomes. Critical to improving outcomes rather than just temporarily reducing costs will be the expansion of adoption of the Patient Centered Medical Home model among primary-care providers while implementing the support structures and reimbursement changes necessary for their success.

Second is the transition of Medicaid reimbursements into value-based payment systems. Value-based payments are designed to change how healthcare is organized and delivered by changing how healthcare services are reimbursed. This multi-year activity will partner with accountable-care entities to transition networks of providers into delivery systems that focuses on whole-person care while responsibly managing resources. This activity will build upon the state's PCMH efforts through the inclusion of specialists, hospitals and other providers within these accountable networks.

Performance Measures:
- By August 2018, enhance the Medicaid Patient Centered Medical Home program to include a shared-savings component in support of primary-care transformation.
- By December 31, 2018, design episode-of care payment bundles for Medicaid in support of specialty physician transformation. Implement at least one category of bundles, such as maternity or orthopedics
- By January 31, 2019, transform primary practices in Idaho to certified Patient-centered Medical Homes
- By January 31, 2019, connect PCMHs to the Idaho Health Data Exchange (IHDE)
- By January 31, 2019, establish virtual PCMHs in rural communities
- By January 31, 2019, ensure connected PCMHs have access to statewide data analytics
- By January 31, 2019, stand-up Regional Collaboratives to provide quality improvement and Medical Health Neighborhood integration services
- By January 31, 2019, Collaborate with providers, health systems and industry experts in adapting a series of value-based payment systems for use by Idaho Medicaid. Complete initial program design by September 2017.
- Work outside the Medicaid program, with provider systems and commercial payers, expanding the adoption of value-based programs and creating a critical mass necessary to support providers who are transforming their business model.
- By January 31, 2019, transform primary practices in Idaho to certified Patient-centered Medical Homes (PCMH)

- By December 31, 2019, implement at least one Regional Care Organization (RCO) by December 31, 2018 in support of health system transformation. Implement a second RCO

Strategic Initiative:
Address Gap Population Health Care and Access Needs

Initiative Description:
With this initiative, the Department seeks solutions to provide health care coverage for the "gap" population. The Medicaid Redesign Workgroup established by Gov. Otter recommended the state change Medicaid eligibility requirements for the 78,000 Idahoans who make less than 100 percent of the federal poverty level because they don't make enough to earn a tax credit to help pay for insurance on the state-based exchange, and they don't earn enough to pay for health insurance outright. There is no consensus among policy makers in the state that expanding Medicaid is the best solution. The Department remains poised to work with policy makers to explore options and develop solutions for health care coverage for this population.

Performance Measures:
- Reduction in episodic and acute health care costs
- Number of new lives attributed to routine sources of care

Strategic Initiative:
Implement Youth Empowerment Services (YES) System of Care

Initiative Description:
With this initiative, the Department will develop and implement a children's mental health system of care (SoC) that is community-based, easily accessed and family-driven and operates with other features consistent with the System of Care Values and Principles.

Performance Measures:
- By 12/31/2018, implement the Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment[1] to establish a threshold of current class member functional impairment and levels of care
- By 9/30/2019, complete an evaluation of CANS to determine changes in functional impairment as a result of the treatment and support delivered under the Youth Empowerment Services (YES) system of care
- By 1/31/2020, develop a Quality Management, Improvement, and Accountability Plan and full system performance measures
- By 12/31/2020, complete all Jeff D. implementation plan action items

[1] The CANS Assessment is a multi- purpose tool developed to support care planning and level of care decision-making, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

Environmental Factors Affecting Achievement of This Objective

Environmental factors beyond the control of the Department that may impact our ability to transform Idaho's health care delivery system include the following:

- Possible resistance from health care providers and payers to move from current fee-for-service model to a value-based model
- Possible lack of resources in rural areas of Idaho
- Resistance from patients and their families to more actively participate in their own health care
- Changes in federal requirements or federal funding
- The amount of financial resources appropriated to deliver services

DHW Strategic Goals:

Goal #1: *Improve the health status of Idahoans.*

Goal #2: *Increase the safety and self-sufficiency of individuals and families*

Goal #3: *Enhance the delivery of health and human services.*

OBJECTIVE #2

Protect Children and Vulnerable Adults

Strategic Focus:

The Department's general operations are administered to protect children and vulnerable adults. With this strategic plan, the Department will also place priority and focus on establishing improved systems of care to achieve the following outcome:

- Children and vulnerable adults are safe and protected from abuse, neglect, self-harm, and exploitation.

Indicators of Success:

- Fewer children re-enter foster care after one year
- Fewer children re-enter foster care between one and five years
- Fewer children re-enter foster care after five years
- Fewer occurrences of harm, abuse, or neglect of children who are in foster care each year
- Individuals with mental illness or developmental disabilities who are a danger to others are able to access treatment in secure facilities
- Increased percentage of individuals with Severe and Persistent Mental Illness (SPMI) and difficult behaviors who are in stable residential settings

Three initiatives have been launched as part of the Department's Strategic Plan toward achievement of the strategic outcome and Objective #2. Those initiatives are introduced below:

Strategic Initiative:

Develop a Therapeutic Stabilization and Transition Center for Clients with Developmental Disabilities

Initiative Description:

The courts continue to assign DHW with the care of individuals who are severely developmentally disabled and who are a threat to themselves and/or others. The Department is in the process of securing the proper facilities and developing the services to adequately care for and treat this population as well as developing rules to establish a new facility type and the state licensing requirements.

Performance Measures:

- By July 1, 2018, establish a new facility type, Secure Treatment Facility, and the state licensing requirements for the new facility type
- By July 1, 2018, establish a Secure Treatment Facility for people with developmental disabilities and mental illness requiring short-term or crisis stabilization
- By July 1, 2020, develop the capacity for safe evaluation and treatment of individuals committed to the Department for placement, evaluation, and competency training

Strategic Initiative:
Ensure Long-term Residential Care for Individuals with Chronic Mental Illness

Initiative Description:
Idaho struggles to meet the needs of its citizens with mental illness whose illness is not severe enough to require hospitalization but who also can't live independently because of their illness. Individuals with mental illness are often housed in assisted living facilities that are not well-equipped to meet their mental health needs. The appropriate model for providing the level of support necessary to safely manage and effectively treat patients with mental illness of a certain severity does not exist in Idaho. This strategic initiative is designed to establish a best practice model to meet the needs of this population and those who care for them.

Performance Measures:
- By July 1, 2018, pilot a new residential setting, Homes for Adult Residential Treatment (HART), in at least three different locations in the state that provides more cost effective treatment than currently financed by the state to support Idahoans with serious mental illness that cannot live independently
- By July 1, 2018, implement a reimbursement mechanism to adequately reimburse providers for the treatment and support of Idahoans with serious mental illness to save the state more expensive treatment elsewhere
- By July 1, 2020, construct a Nursing Home, on the State Hospital South campus, that adequately meets the needs of the those who qualify for nursing home care, with behavioral health needs, 65 years of age or older

Strategic Initiative:
Transform Child Welfare Systems to Improve Outcomes for Children

Initiative Description:
This initiative involves several projects which include many stakeholders and partners. It involves changing and streamlining processes, enhancing Department infrastructure, improved coordination with critical stakeholders and partners (like law enforcement, education, courts, tribes, and the medical and behavioral health communities), upgrading technology, improved programs (like the foster care program), and legal representation for the Department in court. This initiative is important as we strive to

gain better long-term outcomes for today's children in care. These children today are the adults of tomorrow who will either be in prison, on the streets, or in professional careers leading productive lives with healthy families of their own. Society as a whole can be better with the successful completion of this initiative. If we don't complete it, there are higher costs to tax payers, and higher emotional prices paid by children which will continue to plague them into adulthood.

Performance Measures:

- By July 1, 2018, the Department will advance legislation to obtain party status in child protection cases and ensure consistent agency representation in child protection cases.
- By July 1, 2019, ensure timeliness of initiating safety assessments (both response time and timeliness in seeing the child(ren)) as outlined in IDAPA 16.06.01.554 at or above 88.5%.
- By July 1, 2020, increase response rates to our resource parent annual surveys from 10-15% to 30-40%.
- By July 1, 2020, increase the number of youth age 14 and over who have completed a life skills assessment within 90 days of eligibility to 80% or above and increase the number of youth with an independent living plan to 68% percent within 90 days of eligibility.
- By July 1, 2020, maintain or increase placement stability to higher than the federal outcome standard (4.12 moves per 1,000 days in care)
- By July 1, 2020, decrease turnover rates among child welfare social workers and supervisors from 10-15% to 5-10%.
- By July 1, 2020, increase the response rates to staff surveys and evaluations on effectiveness and satisfaction of trainings and resources offered from 25-45% to 60-80%.
- By July 1, 2020, maintain or reduce re-entries into foster care to below the federal outcome standard (8.3%)
- By July 1, 2020, maintain or reduce instances of repeat maltreatment to below the federal outcome standard (9.1%)
- By July 1, 2020, the program will have sustained improvement at or above 90% on the program's goal for Family Involvement in Case Planning from the results of the program's Case Record Reviews
- By July 1, 2020, the program will increase response rates to stakeholder surveys from 10- 20% to 30 -40%.
- By July 1, 2020, the program will ensure early and timely permanency for all children in foster care (maximums – 12 months to reunification, 13 months to guardianship, or 24 months to adoption per state statute)

Environmental Factors

Environmental factors beyond the control of the Department that may impact our ability to protect children and vulnerable adults include the following:

- Availability of individual insurance coverage
- Affordability and provision of health care coverage by employers

- Access to health care services
- The availability of health care professionals in rural and urban settings
- Health care provider priorities and practice patterns
- Resources available in local communities to support individuals with chronic mental illness or substance use disorders
- Economic and social factors contributing to family crises and the abuse and neglect of children and vulnerable adults
- Changes in federal requirements or federal funding
- The amount of financial resources appropriated to deliver services

DHW Strategic Goals:

Goal #1: *Improve the health status of Idahoans.*
Goal #2: *Increase the safety and self-sufficiency of individuals and families*
Goal #3: *Enhance the delivery of health and human services.*

OBJECTIVE #3

Promote stable and healthy individuals, families, and populations through medical coverage, program access, support services, and policy

Strategic Focus:
The Department's general operations are administered to promote stable and healthy individuals, families, and populations through medical coverage, program access, support services, and policy. With this strategic plan, the Department will also place priority and focus on achieving the following outcomes:

- Decreased rate of deaths by suicide in Idaho
- Decreased rate of suicide attempts in Idaho
- Increased access to suicide prevention resources and treatment
- Provide sustainable funding to the Idaho Suicide Prevention Hotline
- Developmentally disabled (DD) children and adults receive services they need and qualify for that improve their lives
- The DD service system is transparent and improving
- Individuals with DD are served by providers, programs, and stakeholders with a shared vision through collaborative efforts

Indicators of Success:
- Rate of referrals to mental health services for people with suicide ideation and attempts
- Rate of hotline call captures
- Reach of suicide intervention activities
- Reach of suicide postvention activities
- Percentage of middle and high schools trained in life-long resilience and well-being
- Individuals with disabilities seamlessly transition between services and throughout the lifespan
- DD services address needs for employment, integration, therapy, supports, safety and self-determination
- Idaho person centered planning techniques are created and utilized for individuals with disabilities

Two initiatives have been launched as part of the Department's Strategic Plan toward achievement of the strategic outcomes and Objective #3. Those initiatives are introduced below:

Strategic Initiative:
Implement Comprehensive Suicide Prevention Strategies

Initiative Description:
With this initiative, the Department will convene stakeholders and lead the efforts to implement the State Suicide Prevention Plan. The Idaho Suicide Prevention Plan is intended to empower communities in providing suicide prevention, intervention and response to suicide attempts and completions.

Performance Measures:

- By July 1, 2018, air public awareness campaign public service announcements
- By July 1, 2018, distribute public awareness campaign collateral materials statewide
- By July 1, 2018, five Zero Suicide Health System Partners have developed and/or implemented Zero Suicide action plans
- By July 1, 2018, 50 behavioral health clinicians have been training in suicide assessment and management
- By July 1, 2018, provide 10 suicide prevention gatekeeper trainings to professionals and community members
- By July 1, 2018, provide suicide survivor packets to survivors of suicide loss
- By July 1, 2018, provide materials about suicide prevention and lethal means to 20% of Idaho gun shops, gun ranges and firearms instructors
- By July 1, 2018, commit ongoing financial support to the Idaho Suicide Prevention Hotline
- By July 1, 2018, provide training in life-long resilience and well-being to 25% of middle and high schools

Strategic Initiative:
Develop the System for Comprehensive Oversight of Delivery of Services to Individuals with Developmental Disabilities

Initiative Description:
Currently, services for individuals with developmental disabilities are managed and delivered from different organizational units within the Department. This initiative will focus on examining current processes to better coordinate services and gain efficiencies and possible cost savings as well as ensuring we are delivering services to this population in a comprehensive manner from birth through adulthood.

Performance Measures:

- Gaps in services for individuals transitioning between early intervention and children's services are at 0%. Occurrence of gaps in services between children and adult programs should not to exceed 5%.

- Development, implementation, and publication of DD specific QA/QI measures across the lifespan and services array
- Increased collaboration and formal agreements between Department DD Programs and other DD Programs such as Adult Protection and Vocational Rehabilitation
- Development of efficient and understandable description and entry tools allowing individuals' easier access to services and supports
- By July 1, 2018, finalize a five-year plan for developmental disability services with the input of participants, providers, and community advocates

Environmental Factors

Environmental factors beyond the control of the Department that may impact our ability to promote stable and healthy families, individuals, and populations include the following:

- The availability of services. Local communities and private healthcare providers are not mandated to provide services in a particular locality. Providers may not offer services in rural areas where it is not economically feasible. If local services are not available, the Department must provide services
- Community acceptance of people with physical or mental challenges is beyond the Department's control. If those capable of living independently are not accepted in community neighborhoods, there is a good chance these individuals will have to return to an institution, for they will have no other option
- Changes in federal requirements
- The amount of financial resources appropriated to deliver services
- Resources available in local communities to support individuals with chronic mental illness or substance use disorders
- Resistance from individuals and their families to more actively manage their own health and stability
- The stigma attached to those individuals and families who receive public services

Additional Strategic Initiatives

The strategic initiatives outlined in the previous pages of this plan are initiatives which improve and enhance the delivery of services in the Department and directly contribute to achievement of the Department's three strategic objectives.

There are three additional strategic objectives that contribute indirectly to the Department's strategic goals and objectives, and they position the Department to successfully complete the other initiatives and achieve the Department's strategic goals and objectives. Those initiatives are outlined below:

Strategic Initiative:
Integration of Information Systems

Initiative Description:
With this initiative, the Department will develop and implement policies and technology that integrate data across organizational units.

Performance Measures:

- By July 1, 2020, decommission redundant and outdated software and technology or move to an improved technological platform
- By July 1, 2020, consolidate servers and technology
- By July 1, 2020, eliminate obsolete rules engines
- By July 1, 2020, consolidate web application firewalls
- By July 1, 2020, consolidate perimeter firewalls

Strategic Initiative:
Be a catalyst for implementation of a new statewide accounting system.

Initiative Description:
With this initiative the Department will coordinate with the Office of the State Controller (SCO), the Division of Financial Management (DFM), and the Legislative Services Office (LSO) as the state works toward the possible replacement of both the Department's and the State of Idaho's accounting system. The purpose of this coordination is to create an environment that mitigates risks typically associated with a significant change in a state's multi-agency accounting infrastructure.

Performance Measures:

- Continue to work with SCO, DFM and LSO in Idaho's statewide accounting modernization planning and development efforts
- Continue to develop, document, and analyze "as is" and "to be" documentation for the Department's most critical administrative and financial business processes

- Continue to coordinate, analyze, and support the effort to identify the future state requirements for the core administrative and financial systems statewide alongside SCO, DFM, and LSO
- Complete the design and documentation of a future state-wide chart of accounts alongside SCO, DFM, and LSO
- Determine and implement the organizational structure within the Department's Office of Financial Services necessary to support the current as-is business processes, as well as the needs of the Idaho Statewide Infrastructure Modernization (ISIM) project
- Start preparing for the migration of the Department's financial data by executing the following:
    - Analysis of current financial data
    - Documentation of data conversion risk assessment for all automated financial system processes
        Example: cleansing of invalid vendor records
    - Implement clear agency-wide expectations and/or standards for critical areas of anticipated data conversion
        Example: vendor/payee records management

Note: Target dates for the above measures have not been set as those dates are dependent on the Department's partners in this initiative.

Strategic Initiative:
"Live Better Idaho" Initiative

Initiative Description:
With this initiative, the Department will address the following priorities:

- To provide a useful and relevant virtual connection to services by creating a consumer-focused, goal-oriented site, where a consumer can find the services that connect and serve their families. This concept would cross divisions, agencies, and community partners and would focus on services that help Idaho families live better, healthier, and more productive lives. It would identify the services from a decision to improve the quality of life, rather than an entitlement or government handout. This website also will help consumers connect beyond the walls of DHW and see that communities offer many resources and opportunities to help them "Live Better."
- To change the environment in DHW field offices, which is the place where many of the department's clients interact with staff and services. The department will create an environment where Idahoans and their families go to make informed choices about how to improve their lives and become healthier and more self-reliant. By changing the environment and focus from entitlement programs to empowerment programs, we will position our consumers and staff to help move individuals and families to stronger stability and longer term sustainability.

- Identify partnerships across agencies to help connect services which will better align education, training and employment services, and human and social services among public and agencies and employers that will create positive pathways for families to become self-reliant and successful in the workforce.

Performance Measures:

- By July 1, 2018, improve consumer access to information and services through the web
- By July 1, 2018, improve culture and conversation through customer interactions on the phone
- By July 1, 2018, create new focus on nutrition, health, and improved lifestyle in offices and through written materials
- By July 1, 2018, develop partnerships with other agencies to identify services that align with the vision of Live Better Idaho and develop a community of resources and information that inform and empower Idaho families and citizens in a positive way
- By July 1, 2018, all divisions within the Department of Health and Welfare will make relevant services available to customers on the Live Better Idaho site

Cybersecurity Executive Order 2017-02 Compliance:

Executive Order 2017-02 has mandated that every agency must include this section to their state strategic plans to report progress in complying with specific requirements outlined in the Executive Order. The Department's progress is described below:

- *Concerning the requirement related to immediate adoption of the National Institute of Standards and Technology's (NIST) Cybersecurity Framework, the NIST framework was adopted by our agency in 2013 due to the federal audits and regulations governing information system security. Furthermore, Richard Armstrong, Director of Health and Welfare sent a memorandum to Susan Buxton, Idaho Division of Human Services (IDHR) Administrator, confirming our adoption of this framework.*

- *Concerning the requirement that all executive branch agencies implement the first five Center for Internet Security Critical Security Controls (CIS Controls) by June 2018, the Department is nearly 85 percent complete in implementing the five controls and will perform a gap analysis to determine what is needed to meet this objective.*

- *Concerning the requirement that all executive branch agencies develop employee education and training plans within the first 90 days of this execution order, the Department already had a federal requirement to provide this training to all employees and continues to do so. A detailed training plan was provided to IDHR describing our required training in detail. The security training provided is SANS – Securing the Human. The recommendation for our agency is to make this training a development objective as part of every employee's annual evaluation to ensure compliance.*

- *Concerning the requirement that all executive branch agencies require their employees to complete the state's annual cybersecurity training commensurate with their highest level of information access and core work responsibilities, the SANS training provided by the department offers four levels of training depending on their access and core work responsibilities.*

ATTACHMENT 14

Idaho Department of Health and Welfare's Response to the Opioid Epidemic

August 2017

Idaho has seen a steadily increasing number of overdose deaths since 2001.

- The rate of age-adjusted drug-poisoning deaths in Idaho is not significantly different than the national rate of 13.1 per 100,000 reported from 1999 through 2012.
- In 2015, Idaho experienced 223 deaths from drug overdose, yielding an age-adjusted mortality of 14.6 per 100,000 residents, almost double the rate of 7.9 per 100,000 residents in 2001 (Idaho Division of Public Health, Bureau of Vital Records and Health Statistics).
- In 2015, unintentional poisoning was the leading cause of injury deaths in in Idaho residents age 35-54. Opioids are frequently implicated; in 2015, 93 (42%) deaths were directly attributed to opioids, and 64 of these were due to prescription opioid pain relievers. This is almost certainly an underestimate, since in Idaho, 25% of overdose deaths have no specific drug listed.

The Division of Public Health was the recipient of funding for both the Planning and Data (base) and the Prevention in Action (enhanced) components of the CDC-RFA-CE16-1606 Prescription Drug Overdose: Data-Driven Prevention Initiatives award. Funds awarded in September 2016 for Year 1 of an expected three-year award are **$575,988.00. An application for Year 2 for the same amount was submitted in May and should be awarded by Sep 1, 2017.**

Strategies include:

- **Development of a state-wide strategic plan through the Office of Drug Policy.** A Strategic Planning Retreat took place in April, 2017. The final document will be completed by September 30, 2017, and quarterly strategic planning meetings are anticipated in the next year to refine planned activities, assign responsible parties, assess progress, and maintain momentum.
- **Enhancement of data quality and availability of data for public health purposes.** DPH is contracting with the Board of Pharmacy to obtain PDMP data reports, working to improve death reporting through training of county coroners and funding for toxicology testing, and investigating use of complementary sources of data such as syndromic surveillance, EMS run data, and poison control center data.
- **Development of a data dashboard.** Initial work has begun to display drug-related death data obtained from Idaho's Bureau of Vital Records and Health Statistics in an interactive format (Tableau) on a public-facing website.
- **Integration of the PDMP into electronic health records (EHRs).** The DPH has contracted with the Board of Pharmacy to educate health agencies and pharmacies about benefits of direct integration of PDMP data into electronic health records, and support acquisition.
- **Prescriber outreach.** DPH has granted subawards to Idaho's seven local public health districts, who are educating physicians on the use of the Idaho PDMP and the CDC Guideline for Prescribing Opioids for Chronic Pain.

Supplemental funds of **$460,782**.00 have also been requested July 31, 2017, by the Division of Public Health, anticipated to be awarded by September 1, 2017, to:

- **Implement a communications plan** based on the CDC Campaign Implementation Toolkit with content tailored to specific audiences and communication needs within Idaho.
- **Develop educational materials and outreach activities for healthcare providers** including prescribers and pharmacists on the use of the Idaho Prescription Drug Monitoring Program, naloxone co-prescribing, and best practices for opioid prescribing.

The Notice of Award is expected in the near future with programming to begin September 1, 2017.

The Division of Behavioral Health uses federal and state funds to provide treatment and recovery support services for individuals with substance use disorder (SUD). Over the last 3 years, we have seen a significant increase in the amount of funding that is being utilized by individuals who claim that opioids and/or heroin are one of the substances with which they struggle. The table below shows the funding for behavioral health services to address the opioid crisis.

	Federal Fiscal Year 2014	Federal Fiscal Year 2015	Federal Fiscal Year 2016
Idaho Department of Health and Welfare	$1,133,408.05	$1,899,241.35	$2,167,488.17

In addition, the Division of Behavioral Health was awarded $2 million to address the opioid epidemic in April 2017. Idaho's project is called **IROC: Idaho's Response to the Opioid Crisis** and contains 4 components:

- **Introduce publicly-funded MAT to Idaho** by adding Methadone and Suboxone to the array of treatment and recovery support services that are currently available. Individuals with OUD who are eligible for SUD-related services will be able to access these medications at various locations throughout the state. This will be accomplished by increasing the number of Suboxone and Methadone providers in Idaho, training traditional treatment providers in evidence-based treatment models focused on OUD, and by creating a system in which traditional treatment providers can refer individuals to MAT services. Through the MAT program, IROC will seek to provide services to 250 Idahoans or more per year.

- **Prevention Activities:**
  - **Using prescriber report cards** to create social norms of decreased opioid prescribing;
  - Reducing diversion of opioids by **establishing drop-box programs in pharmacies** statewide; and
  - **Educating prescribers** on use of the Prescription Drug Monitoring Program (PDMP) and the CDC's prescribing guidelines which will result in fewer prescriptions for opioids being written and filled.

  Among other objectives, these steps seek to reduce the number of prescriptions per capita by 5%, decrease the percentage of patients on high dose opioid therapy by 5%, and increase the rate of PDMP use by 10% within a one year period.

- **A recovery oriented system of care** will broaden the boundaries of a traditional treatment system emphasizing services to engage persons in a recovery process from the point of initial contact. Among other objectives, this system of care seeks to reduce overdose events and fatalities, reduce "no shows" through immediate contact with a peer, and to help support services and sober recreational activities to the OUD population.

- **Increase the use of Naloxone** to reverse opiate overdoses through training and provision of naloxone to first responders and others (including FQHCs) and other community members who may come in contact with individuals, at risk of opiate overdose. This will be accomplished by identifying a minimum number of first responder agencies that will begin carrying Naloxone, community and provider trainings, and by providing naloxone kits to identified and trained entities.

  More information on IROC can be found at www.iroc.dhw.idaho.gov

  Finally, as a condition of this funding, DBH is required to submit an **Opioid Needs Assessment.** That assessment has been completed and is currently undergoing review by DHW's Public Information Office before it can be disseminated. Another requirement of the grant is that we submit a strategic plan. As mentioned above, Idaho's strategic plan was developed with grants funds received by DPH. By partnering, we are able to eliminate redundant work and focus on one consistent strategic plan that will guide all involved parties in Idaho, rather than having two separate plans.

Both Divisions continue to work closely together, and are partnering actively with the local public health districts, the Board of Pharmacy, Idaho State University, the Office of Drug Policy, and many other stakeholders participating in Strategic Planning in the fight to end this epidemic before more lives are needlessly lost.